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MONTANA LEGISLATIVE HISTORY

Chapter 550 19 91

Bill H _____ S 172 Original bill & history ✓C

H. Committee on Human Services		S. Committee on Pub. Health	
Hearing Date(s) _____	___C	Hearing Date(s) _____	___C
3/22	___C	2/6	✓C
_____	___C	_____	___C
_____	___C	_____	___C
Date Out 3/27	✓C	DATE OUT 2/13	✓

Did this bill originate in an interim committee? ___Yes ___No

Committee _____ Report _____

3/23	2ND READING AMENDMENTS NOT CONCURRED	29	15
3/28	CONFERENCE COMMITTEE APPOINTED		
4/05	CONFERENCE COMMITTEE DISSOLVED		
4/05	FREE CONFERENCE COMMITTEE APPOINTED		
4/08	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/09	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	40	5
4/10	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	39	11
	HOUSE		
4/03	CONFERENCE COMMITTEE APPOINTED		
4/06	CONFERENCE COMMITTEE DISSOLVED		
4/06	FREE CONFERENCE COMMITTEE APPOINTED		
4/08	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/10	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	68	30
4/11	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	72	35
4/19	SIGNED BY PRESIDENT		
4/20	SIGNED BY SPEAKER		
4/20	TRANSMITTED TO GOVERNOR		
4/24	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 592	EFFECTIVE DATE: 3/01/92	

SB 172 INTRODUCED BY SVRCEK, ET AL.
PROVIDE FOR LICENSING AND REGULATION OF DIRECT-ENTRY MIDWIVES

1/22	INTRODUCED		
1/22	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
1/22	FIRST READING		
1/22	FISCAL NOTE REQUESTED		
1/29	FISCAL NOTE PRINTED		
2/06	HEARING		
2/16	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/18	2ND READING PASSED	38	8
2/19	3RD READING PASSED	46	4
	TRANSMITTED TO HOUSE		
2/27	FISCAL NOTE RECEIVED		
3/04	FIRST READING		
3/04	REFERRED TO HUMAN SERVICES & AGING		
3/22	HEARING		
3/28	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
4/05	2ND READING CONCURRED	90	9
4/06	3RD READING CONCURRED	86	11
	RETURNED TO SENATE WITH AMENDMENTS		
4/09	2ND READING AMENDMENTS CONCURRED	45	0
4/10	3RD READING AMENDMENTS CONCURRED	50	0
4/17	SIGNED BY PRESIDENT		
4/18	SIGNED BY SPEAKER		
4/18	TRANSMITTED TO GOVERNOR		
4/23	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 550		
	EFFECTIVE DATE: 04/23/91 - SECTIONS 5, 6, 26, 27		
	EFFECTIVE DATE: 07/01/91 - SECTIONS 1-4, 7-25		

SB 173 INTRODUCED BY BLAYLOCK, ET AL.
REVISE CAMPAIGN FINANCE LAWS
BY REQUEST OF COMMISSIONER OF POLITICAL PRACTICES

1/22	INTRODUCED
1/22	REFERRED TO STATE ADMINISTRATION
1/22	FIRST READING
1/25	HEARING
1/25	COMMITTEE REPORT—BILL PASSED

Senate BILL NO. 172

INTRODUCED BY [signatures]

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE LICENSING AND REGULATION OF DIRECT-ENTRY MIDWIVES; CREATING A BOARD OF DIRECT-ENTRY MIDWIFERY; PROVIDING FOR LICENSING, INCLUDING PROVISIONAL LICENSES AND APPRENTICE LICENSES; ESTABLISHING LICENSE EXEMPTION REQUIREMENTS; CREATING A COMMUNICATIONS PRIVILEGE; PROVIDING FOR LICENSING RECIPROCITY; REQUIRING INFORMED CONSENT; ESTABLISHING CLIENT SCREENING PROCEDURES; PROVIDING FOR PHYSICIAN CONSULTATION; REQUIRING THE FILING OF BIRTH CERTIFICATES AND REPORTS; PROVIDING FOR AN ADMINISTRATIVE FINE, A CRIMINAL PENALTY, AND AN INJUNCTION; GRANTING THE BOARD RULEMAKING AUTHORITY; AMENDING SECTIONS 27-1-734 AND 37-3-103, MCA; AND PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section 6] grants rulemaking authority to the board of direct-entry midwifery to implement the provisions of this bill. In adopting rules, the board is encouraged to review regulations promulgated by the state of New Hampshire and, where appropriate, to adopt comparable rules specifically applicable to direct-entry midwifery in Montana. At a minimum, it is the intent of the legislature that the board adopt rules:

(1) governing the conduct of board business;

(2) establishing license application and examination procedures, criteria for and grading of examinations, examination and license fees, criteria for minimum educational, apprenticeship, and clinical requirements for license eligibility, and continuing education requirements for license renewal;

(3) establishing eligibility criteria for client screening by direct-entry midwives;

(4) developing procedures for the issuance, renewal, suspension, revocation, and reciprocity of licenses;

(5) creating disciplinary standards for licensees, establishing investigatory procedures for processing complaints, and adopting ethical standards for licensed direct-entry midwives;

(6) establishing supporting documentation for primary birth attendants; and

(7) establishing standardized informed consent and reporting forms.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1.** Short title. [Sections 1 through 4 and 6 through 23] may be cited as the

INTRODUCED BILL
SB 172

"Direct-Entry Midwifery Licensing Act".

NEW SECTION. **Section 2.** **Purpose.** The legislature finds and declares that because the practice of direct-entry midwifery affects the lives of the people of this state and because some Montanans may exercise their right to give birth where and with whom they choose, it is the purpose of [sections 1 through 4 and 6 through 23] to provide for the common good by ensuring the qualified and professional practice of direct-entry midwifery.

NEW SECTION. **Section 3.** **Definitions.** As used in [sections 1 through 4 and 6 through 23], the following definitions apply:

(1) "Apprentice" means a person who is working under the supervision of a licensed direct-entry midwife and is seeking licensure as a direct-entry midwife under [sections 1 through 4 and 6 through 23].

(2) "Board" means the board of direct-entry midwifery established in [section 5].

(3) "Continuous care" means care provided for one person from the initial history-taking interview through monthly prenatal, intrapartum, and postpartum periods.

(4) "Department" means the department of commerce provided for in 2-15-1801.

(5) "Direct-entry midwife" means a person who advises, attends, or assists a woman during pregnancy, labor, natural

childbirth, or the postpartum period.

(6) "Licensee" means a person authorized by [sections 1 through 4 and 6 through 23] to practice direct-entry midwifery.

(7) "Practice of direct-entry midwifery" means the advising, attending, or assisting of a woman during pregnancy, labor, natural childbirth, or the postpartum period.

NEW SECTION. **Section 4.** **Exemptions.** Sections 1 through 4 and 6 through 23] do not limit or regulate the practice of a licensed physician, certified nurse-midwife, or licensed basic or advanced emergency medical technician. The practice of direct-entry midwifery does not constitute the practice of medicine, certified nurse-midwifery, or emergency medical care to the extent that a direct-entry midwife advises, attends, or assists a woman during pregnancy, labor, natural childbirth, or the postpartum period.

NEW SECTION. **Section 5.** **Board -- composition -- allocation -- quasi-judicial -- compensation.** (1) There is a board of direct-entry midwifery.

(2) The board is composed of five members, all of whom support the practice of direct-entry midwifery. Members are appointed by the governor to serve staggered 4-year terms. The board consists of:

(a) three members who are direct-entry midwives who

filed the affidavit required by 37-75-102. Subsequent appointments may be made only from those direct-entry midwives who are licensed pursuant to [sections 1 through 4 and 6 through 23].

(b) one member who is a physician whose practice includes obstetrics; and

(c) one member of the general public.

(3) The board is allocated to the department of commerce for administrative purposes only as prescribed in 2-15-121.

(4) The board is designated as a quasi-judicial board for purposes of 2-15-124.

(5) Members of the board are entitled to compensation and travel expenses.

NEW SECTION. **Section 6.** General powers and duties of board -- rulemaking authority. (1) The board shall:

(a) meet at least once annually, and at other times as agreed upon, to elect officers and to perform the duties described in this section; and

(b) administer oaths, take affidavits, summon witnesses, and take testimony as to matters within the scope of the board's duties.

(2) The board shall have the authority to administer and enforce all the powers and duties granted statutorily or adopted administratively.

(3) The board shall adopt rules to administer [sections 1 through 4 and 6 through 23]. The rules must include but are not limited to:

(a) the development of a license application and examination, criteria for and grading of examinations, and establishment of examination and license fees commensurate with actual costs;

(b) the issuance of a provisional license to midwives who filed the affidavit required by 37-75-102;

(c) the establishment of criteria for minimum educational, apprenticeship, and clinical requirements that, at a minimum, meet the standards established in [section 7];

(d) the development of eligibility criteria for client screening by direct-entry midwives;

(e) the development of procedures for the issuance, renewal, suspension, revocation, and reciprocity of licenses;

(f) the adoption of disciplinary standards for licensees;

(g) the establishment of investigatory and hearing procedures for processing complaints received by the board;

(h) the establishment of continuing education requirements of at least 10 hours annually for license renewal for direct-entry midwives;

(i) the development of standardized informed consent

and reporting forms;

(j) the adoption of ethical standards for licensed direct-entry midwives; and

(k) the adoption of supporting documentation requirements for primary birth attendants.

NEW SECTION. **Section 7. Qualifications of applicants for license -- educational and practical experience requirements.** To be eligible for a license as a direct-entry midwife, an applicant:

(1) must be of good moral character and be at least 21 years of age;

(2) shall satisfactorily complete educational requirements in pregnancy and natural childbirth, approved by the board, which must include but are not limited to the following:

(a) provision of care during the antepartum, intrapartum, postpartum, and newborn period;

(b) parenting education for prepared childbirth;

(c) observation skills;

(d) aseptic techniques;

(e) management of birth and immediate care of the mother and the newborn;

(f) recognition of early signs of possible abnormalities;

(g) recognition and management of emergency situations;

and

(h) special requirements for home birth;

(3) shall acquire practical experience, which may be attained in a home, clinic, or hospital setting. Practical experience attained in a hospital does not constitute training or supervision by the hospital. At a minimum, this experience must include the following types and numbers of experiences acquired through an apprenticeship or other supervisory setting:

(a) provision of 100 prenatal examinations;

(b) observation of 40 births; and

(c) participation as the primary birth attendant at 25 births, 15 of which included continuous care, as evidenced by signing the birth certificate as the primary birth attendant.

(4) shall file documentation with the board that the applicant has been certified by the American heart association or American red cross to perform adult and infant cardiopulmonary resuscitation. Certification must be current at the time of application and remain valid throughout the license period.

NEW SECTION. **Section 8. Examination -- exemption.** (1) Except as provided in subsection (4), an applicant for a license as a direct-entry midwife shall pass a qualifying examination, prescribed by the board, that is designed to

test knowledge of theory regarding pregnancy and childbirth and to test clinical judgment in midwifery management. If considered necessary, an oral interview may be conducted to determine the fitness of the applicant to practice as a direct-entry midwife.

(2) Before an applicant may take the examination, the applicant shall demonstrate to the board that the educational and practical experience requirements in [section 7(2) and (3)] have been met.

(3) An applicant is exempt from the study and practical experience requirements of [section 7(2) and (3)] if the applicant has:

(a) satisfactorily completed the first examination given by the board following [the effective date of sections 1 through 4 and 7 through 25]; and

(b) filed supporting documentation, as required by the board by rule, certifying that the applicant has served as the primary birth attendant, providing continuous care at no less than 75 births within the 7 years prior to [the effective date of sections 1 through 4 and 7 through 25] as verified by birth certificates from Montana or another state, a signed affidavit from the birthing mother, or documented records from the midwife.

(4) Upon payment of the license fee established by the board, a nurse-midwife certified pursuant to 37-8-409 is

exempt from the requirements of [section 7 and this section] and may be licensed as a direct-entry midwife.

NEW SECTION. **Section 9.** **Provisional license -- apprentice license.** (1) Upon payment of a $200 fee to the department, the board may grant a provisional direct-entry midwife license only to a person who filed an affidavit required by 37-75-102.

(2) The provisional license is valid until the issuance of grades for the first examination administered pursuant to [section 10].

(3) Upon payment of a $200 fee to the department, the board may grant an apprentice direct-entry midwife license to a person who is working under the personal supervision of a licensed direct-entry midwife and who is seeking licensure as a direct-entry midwife under [sections 1 through 4 and 6 through 23].

(4) An apprentice direct-entry midwife license is valid for 1 year and must be renewed annually, with a limit of four renewals.

NEW SECTION. **Section 10.** **Examination -- preparation -- requirements.** (1) An examination for a license to practice direct-entry midwifery must be prepared by a certified nurse-midwife designated by the board in consultation with the physician on the board.

(2) Examinations must be conducted once each year, be

fair and impartial, and be sufficiently comprehensive to adequately test the applicant's competence and ability.

(3) A person must attain a grade of at least 70% to pass the examination.

NEW SECTION. **Section 11. Administration of prescription drugs prohibited -- exceptions.** A licensed direct-entry midwife may not dispense or administer prescription drugs other than newborn vitamin K, pitosin postpartum, xylocaine, and, in accordance with Rule 16.24.215, Administrative Rules of Montana, prophylactic eye agents to newborn infants. These drugs may be administered only if prescribed by a physician.

NEW SECTION. **Section 12. Operative and surgical procedures prohibited -- exception.** A licensed direct-entry midwife may not perform any operative or surgical procedures except for an episiotomy and simple surgical repair of an episiotomy or simple second-degree lacerations.

NEW SECTION. **Section 13. Fees.** (1) An applicant for a direct-entry midwife license shall, upon submitting an application to the board, pay an application fee set by the board, commensurate with costs.

(2) An applicant required to take an examination shall, before commencement of the examination, pay an examination fee set by the board, commensurate with costs.

(3) Before a license may be issued or renewed, an

applicant shall pay a fee set by the board, commensurate with costs.

(4) Subject to 37-1-101(6), money paid for application, examination, license, and license renewal fees must be deposited in the state special revenue fund for use by the board.

NEW SECTION. **Section 14. Denial, suspension, revocation, or refusal to renew license -- grounds.** (1) The board, after notice and hearing, may reprimand a licensee or deny, suspend, revoke, or refuse to renew the license of a licensee who:

(a) is habitually intoxicated or is addicted to narcotic drugs;

(b) is guilty of immoral or unprofessional conduct as defined by board rule;

(c) is guilty of gross negligence in practicing direct-entry midwifery;

(d) has obtained or attempted to obtain licensure by fraud or material misrepresentation;

(e) is guilty of conduct unbecoming a person licensed as a midwife or of conduct detrimental to the best interests of the public; or

(f) has violated any provision of [sections 1 through 4 and 6 through 23] or a rule adopted by the board.

(2) The board may impose an administrative fine of not

more than $500 per incident for any violation that could result in the suspension or revocation of a direct-entry midwife license. A fine collected under this subsection must be deposited in the state general fund.

NEW SECTION. **Section 15.** **Unlawful to practice without license.** It is unlawful for a person to practice direct-entry midwifery in this state without first obtaining a license under [sections 1 through 4 and 6 through 23].

NEW SECTION. **Section 16.** **Reciprocity.** Upon payment of the license fee provided for in [section 13], the board may grant a license to a person who, at the time of application, is licensed or certified as a midwife in another state if the board determines that the licensing requirements of that state are equal to or exceed the requirements of [sections 1 through 4 and 6 through 23].

NEW SECTION. **Section 17.** **Privileged communications -- exceptions.** A licensee may not disclose any information acquired from clients during consultation in a professional capacity except:

(1) with the written consent of the client or, in the case of the client's death or mental incapacity, with the written consent of the client's personal representative or guardian;

(2) that the licensee need not treat as confidential a communication otherwise confidential that reveals the

contemplation of a crime by the client or any other person or that in the licensee's professional opinion reveals a threat of imminent harm to the client or others;

(3) that if the client is a minor and information acquired by the licensee indicates that the client was the victim of a crime, the licensee may be required to testify fully in relation to the information in any investigation, trial, or other legal proceeding in which the commission of the crime is the subject of inquiry;

(4) that if the client or the client's personal representative or guardian brings an action against a licensee for a claim arising out of the client's interaction with the direct-entry midwife, the client is considered to have waived any privilege;

(5) to the extent that the privilege is otherwise waived by the client; and

(6) as may otherwise be required by law.

NEW SECTION. **Section 18.** **Informed consent.** (1) Prior to accepting a woman for care, a licensed direct-entry midwife shall first obtain written, informed consent from the woman.

(2) Informed consent may be evidenced by a written statement, in a form prescribed by the board and signed by the direct-entry midwife and the woman to whom care is to be given, in which the direct-entry midwife certifies that full

disclosure has been made and acknowledged by the woman on the following:

(a) the direct-entry midwife's educational background;

(b) the nature and scope of the care to be given, including the possibility of and procedure for transport of the patient to a hospital;

(c) the available alternatives to midwifery care;

(d) the fact that the patient has been encouraged to consult with a physician at least twice during the pregnancy; and

(e) whether the midwifery services provided are located more than 50 miles from the nearest hospital.

NEW SECTION. **Section 19.** **Reports -- failure to report.** (1) A licensed direct-entry midwife shall submit semiannually to the board, on forms supplied by the board, a summary report on each patient given care. The report must include vital statistics on each patient and information on the procedures and scope of care administered, including any transport of the patient to a hospital, but may not include information disclosing the identity of the patient.

(2) A licensed direct-entry midwife shall report within 72 hours to the board and to the department of health and environmental sciences any maternal, fetal, or neonatal mortality or morbidity in patients for whom care has been given.

(3) Failure of a direct-entry midwife to submit required reports constitutes grounds to deny renewal of a license.

NEW SECTION. **Section 20.** **Screening procedures.** In addition to meeting the eligibility criteria for client screening established by the board pursuant to [section 6], a direct-entry midwife shall recommend that patients secure the following services by an appropriate health care provider:

(1) the standard serological test as defined in 50-19-101(2) for women seeking prenatal care;

(2) screening for hepatitis B;

(3) maternal serum alpha-fetoprotein test and ultrasound, upon request;

(4) Rh antibody and glucose screening at 28 weeks' gestation, upon request;

(5) nonstress testing by a fetal monitor of a fetus at greater than 42 1/2 weeks' gestation or if other reasons indicate the testing; and

(6) screening for phenylketonuria.

NEW SECTION. **Section 21.** **Physician consultation encouraged.** A licensed direct-entry midwife is encouraged to advise all women accepted for midwifery care to consult with a physician at least twice during the pregnancy.

NEW SECTION. **Section 22.** **Filing of birth certificate.**

(1) When a birth occurs with a licensed direct-entry midwife in attendance, the direct-entry midwife shall prepare and file a birth certificate, as required by 50-15-201, with the department of health and environmental sciences within 30 days of the birth of the newborn.

(2) Failure of a direct-entry midwife to prepare and file the birth certificate constitutes grounds for the suspension or revocation of a license granted under [sections 1 through 4 and 6 through 23].

NEW SECTION. **Section 23.** **Violation -- penalties -- injunction -- manner of charging violation.** (1) A person who violates any provision of [sections 1 through 4 and 6 through 23] or any rule adopted pursuant to [sections 1 through 4 and 6 through 23] is guilty of a misdemeanor and is punishable by a fine not to exceed $500, by imprisonment in the county jail for a term of not more than 6 months, or both.

(2) Notwithstanding any other provisions of [sections 1 through 4 and 6 through 23], the board may maintain an action to enjoin a person from engaging in the practice of direct-entry midwifery until a license to practice direct-entry midwifery is obtained. A person who has been enjoined and who violates the injunction is punishable for contempt of court. The injunction does not relieve the person practicing direct-entry midwifery without a license

from criminal prosecution. The remedy by injunction is in addition to remedies provided for criminal prosecution of the offender. In charging a person in a complaint for injunction or in an affidavit, information, or indictment with a violation of law by practicing direct-entry midwifery without a license, it is sufficient to charge that the person did, on a certain day and in a certain county, engage in the practice of direct-entry midwifery while not having a license to do so, without averring further or more particular facts concerning the violation.

Section 24. Section 27-1-734, MCA, is amended to read:

"**27-1-734. Limits on liability of health care provider in emergency situations.** ~~(1)~~ A physician licensed under Title 37, chapter 3, a nurse licensed under Title 37, chapter 8, or a hospital licensed under Title 50, chapter 5, rendering care or assistance in good faith to a patient of a direct-entry midwife in an emergency situation is liable for civil damages for acts or omissions committed in providing such emergency obstetrical care or assistance only to the extent that those damages are caused by gross negligence or by willful or wanton acts or omissions.

~~(2) The limitations on liability provided in subsection (1) do not apply in the following cases:~~

~~(a) The physician, nurse, or hospital had provided prior medical diagnosis or treatment to the patient for a~~

~~condition--having-a-bearing-on-or-relevance-to-the-treatment of--the--obstetrical--condition--that---required---emergency services.~~

~~(b)--Before--rendering--emergency--obstetrical-services, the--physician,--nurse,--or--hospital--had---a---contractual obligation--or--agreement--with--the-patient,-another-health care-provider,-or-a-third-party-payer-to-provide-obstetrical care-for-the-patient.~~"

Section 25. Section 37-3-103, MCA, is amended to read:

"**37-3-103. Exemptions from licensing requirements.** (1) This chapter does not prohibit or require a license with respect to any of the following acts:

(a) the gratuitous rendering of services in cases of emergency or catastrophe;

(b) the rendering of services in this state by a physician lawfully practicing medicine in another state or territory. However, if the physician does not limit the services to an occasional case or if he has any established or regularly used hospital connections in this state or maintains or is provided with, for his regular use, an office or other place for rendering the services, he must possess a license to practice medicine in this state.

(c) the practice of dentistry under the conditions and limitations defined by the laws of this state;

(d) the practice of podiatry under the conditions and

limitations defined by the laws of this state;

(e) the practice of optometry under the conditions and limitations defined by the laws of this state;

(f) the practice of osteopathy under the conditions and limitations defined in chapter 5 of this title for those doctors of osteopathy who do not receive a physician's certificate under this chapter;

(g) the practice of chiropractic under the conditions and limitations defined by the laws of this state;

(h) the practice of Christian Science, with or without compensation, and ritual circumcisions by rabbis;

(i) the performance by commissioned medical officers of the armed forces of the United States, of the United States public health service, or of the United States veterans' administration of their lawful duties in this state as officers;

(j) the rendering of nursing services by registered or other nurses in the lawful discharge of their duties as nurses or of midwife services by registered nurse-midwives under the supervision of a licensed physician;

(k) the rendering of services by interns or resident physicians in a hospital or clinic in which they are training, subject to the conditions and limitations of this chapter. The board may require a resident physician to be licensed if he otherwise engages in the practice of medicine

in the state of Montana.

(l) the rendering of services by a physical therapist, technician, or other paramedical specialist under the appropriate amount and type of supervision of a person licensed under the laws of this state to practice medicine, but this exemption does not extend the scope of a paramedical specialist;

(m) the rendering of services by a physician assistant-certified in accordance with Title 37, chapter 20;

(n) the practice by persons licensed under the laws of this state to practice a limited field of the healing arts, and not specifically designated, under the conditions and limitations defined by law;

(o) the execution of a death sentence pursuant to 46-19-103; and

(p) the practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, natural childbirth, or the postpartum period. A Except as authorized in [section 11], a direct-entry midwife may not dispense or administer a prescription drug, as those terms are defined in 37-7-101.

(2) Licensees referred to in subsection (1) of this section who are licensed to practice a limited field of healing arts shall confine themselves to the field for which

they are licensed or registered and to the scope of their respective licenses and, with the exception of those licensees who hold a medical degree, may not use the title "M.D." or any word or abbreviation to indicate or to induce others to believe that they are engaged in the diagnosis or treatment of persons afflicted with disease, injury, or defect of body or mind except to the extent and under the conditions expressly provided by the law under which they are licensed."

NEW SECTION. **Section 26.** Codification instruction. (1) [Sections 1 through 4 and 6 through 23] are intended to be codified as an integral part of Title 37, and the provisions of Title 37 apply to [sections 1 through 4 and 6 through 23].

(2) [Section 5] is intended to be codified as an integral part of Title 2, chapter 15, part 18, and the provisions of Title 2, chapter 15, part 18, apply to [section 5].

NEW SECTION. **Section 27.** Effective dates. (1) [Sections 5, 6, 26, and this section] are effective on passage and approval.

(2) [Sections 1 through 4 and 7 through 25] are effective July 1, 1991.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15
In compliance with a written request, there is hereby submitted a Fiscal Note for SB0172, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

The bill provides for the licensing and regulation of direct-entry midwives, creates a board of direct-entry midwifery, provides for licensing including provisional licenses and apprentice licenses, establishes license exemption requirements, and provides for informed consent and physician consultation.

ASSUMPTIONS:

1. The Board of Midwifery will provisionally license 25 applicants during FY92 and will license 15 applicants during FY93. The 25 provisional licenses at $200 each will generate $5,000 in fee revenue during FY92. The board will set the full license application, examination, and license fees which are assumed to be $150, $300, and $300, respectively, for the 15 applicants during FY93.
2. The board will conduct two meetings during FY92 and one meeting during FY93 and each year thereafter. Travel expenses are assumed to be $470 per meeting and each meeting will last about 8 hours.
3. Board operating expenses will include per diem, travel, supplies, communications, postage, printing, and administrative overhead recharges. Administrative overhead expenses must be shown in the Professional and Occupational Licensing Bureau of the Department of Commerce which will include an additional 0.10 FTE.

FISCAL IMPACT:
Department of Commerce - Board of Midwifery

	FY 92			FY 93		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
Expenditures:						
Personal Services	0	1,000	1,000	0	500	500
Operating Costs	0	7,325	7,325	0	7,500	7,500
Equipment	0	300	300	0	0	0
Total	0	8,625	8,625	0	8,000	8,000
Funding:						
License Fees (02)	0	8,625	8,625	0	8,000	8,000
Revenue:						
Midwife Licenses (02)	0	5,000	5,000	0	11,250	11,250

1-25-91
ROD SUNDSTED, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

29 JAN 91
PAUL S. SVRCEK, PRIMARY SPONSOR DATE

MINUTES

MONTANA SENATE
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Chairman Dorothy Eck, on February 6, 1991, at 3:15 p.m.

ROLL CALL

Members Present:

Dorothy Eck, Chairman (D)
Eve Franklin, Vice Chairman (D)
James Burnett (R)
Thomas Hager (R)
Judy Jacobson (D)
Bob Pipinich (D)
David Rye (R)
Thomas Towe (D)

Members Excused: None

Staff Present: Tom Gomez (Legislative Council)
Christine Mangiantini (Committee Secretary)

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Announcements/Discussion:

HEARING ON SENATE BILL 172

Presentation and Opening Statement by Sponsor:

The chairman recognized Senator Svrcek who opened his presentation on Senate Bill 172 by reviewing the midwifery issue. Last session the issue was argued before the Legislature and affirmed the legality of direct-entry midwifery in the State of Montana. Because of the Legislative deadline we were unable to establish licensure. In committee testimony and on the floor of the Senate noted that we would be back this session with a licensure bill. He said they had been working on the legislation for nearly two years. He acknowledged differences between some groups regarding the bill and said he will be offering the committee amendments. He thanked the Montana Medical Association and Dr. Nelson who worked to draft the bill.

Proponents' Testimony:

The chairman recognized Representative Ray Peck who said last session he was chief sponsor of the midwifery legislation and Senator Svrcek carried the bill in the Senate. He said that bill established intent and the current bill establishes the specifics of licensure. He said he has five daughters and none would use a midwife but they all support the legislation. They believe as he does that it is the right of every expectant mother to choose how and where her child will be delivered. This bill provides for that principal. He stated his continued support for the right of every woman to make that choice. He applauded the work that has gone on to draft the bill. He asked the committee to remember the spread at which the bill passed last session.

The second witness to testify in favor of SB 172 was Mona Jamison, representing the Montana Midwifery Association. She said she drafted the bill and said she would be available for any questions on the bill. She said the issue before the committee is midwifery with regulation or midwifery without regulation. Last session midwifery was legalized. In developing the bill she had two goals: 1) to achieve the increase of competency and; 2) to make certain the regulations set reasonable standards. She said they are not doctors or nurses and they know what their limits are and know the services they provide based upon the necessary background. She said the Montana Medical Association voiced support for the bill early in the process. She worked with Dr. Nelson and said the bill reflects the needs brought to her by Dr. Nelson. She said they approached the bill differently. She said standards of competency will improve the services to those who choose to use midwifery. She said after she negotiated for two months with Dr. Nelson the Montana Medical Association came out in opposition to the bill. She spoke about a section in the bill regarding the 50 mile radius of the home to a hospital. She briefly spoke about the provisional license requirement. She strongly supports the bill and asked the committee to think of one thing when they hear the amendments and that is of the woman at home who chooses to have her baby in her environment.

The third witness to testify in favor of SB 172 was Dr. Mary Stranahan, a general practicioner from St. Ignatius. She said she was impressed with the degree of concern midwives show to their patients. She said the committee was being asked to pass the bill in order to standardize the requirements for entry. She said she supported the bill because it provides standard skills and knowledge which guarantees a level of competence, it legitimizes the licensing in the existing profession and provides competent, local care.

The fourth witness to testify in favor of SB 172 was Dolly Browder, a midwife practicing in Missoula. She read a letter from Dr. P.J. Hennessey. See Exhibit #1 for a copy of the letter. She summarized the educational section of the bill.

She asked the committee to support the bill as it is written. and said the bill will help to provide safe home birth for all mothers and babies that choose this method in Montana.

The fifth witness to testify in favor of SB 172 was Pamela Rose, a state registered midwife and private pilot. See Exhibit #2 for a copy of her testimony.

The sixth witness to testify in favor of SB 172 was Pamela Shore, See Exhibit #3 for a copy of her testimony.

The seventh witness to testify in favor of SB 172 was Nancy Clark Keener, graduate of University of Michigan with a Bachelor of Science in Nursing. See Exhibit #4 for a copy of her testimony.

The eighth witness to testify in favor of SB 172 was Larry Peterman, graduate of Montana State University with a degree in Nursing. He works as a registered nurse in St. Patricks Hospital. He has a daughter who was born at home. The care provided by his midwife was excellent, intelligent and conservative. He would like midwives to continue to offer their high level of care to the people of Montana.

The ninth witness to testify in favor of SB 172 was Diane Spizziri. She lives in a rural area and chose a midwife for a home birth because she had no other safe alternative. She is in favor of a licensing procedure for midwifery. Her midwife was extremely qualified and delivered two of her children.

The tenth witness to testify in favor of SB 172 was Connie Rubens, she farms and ranches 35 miles north of Great Falls. She had a baby boy born at home. Her husband and she were very impressed by the skill of her midwife.

The eleventh witness to testify in favor of SB 172 was Kim Ronshaugen. She said two and a half years ago she would have never thought of having a child at home. She moved to Florida when she was five months pregnant and used a midwife to assist with delivery. She recently had another child and chose a home birth with a midwife. She said people need to have the choice.

The twelfth witness to testify in favor of SB 172 was Senator Bob Pipinich, he represents District 33. He said he has no doctors who deliver babies in his area. He has a stack of letters that support the bill.

The thirteenth witness to testify in favor of SB 172 was Dr. Van Kirke Nelson, he practices obstetrics in Kalispell. See Exhibit #5 for a copy of his testimony. He said this legislation is not new but was established during the last regular session. He said he does not believe in midwifery but he has seen the action of the legislature and the vote that was 80 to 20 or thereabouts. He said he has to speak for licensure to protect women having children at home.

He said the legislature has stated that there is a choice. The medical association did support licensure but the support is no longer present. He said he has worked with Mona Jamison on the draft of the bill.

Because of time constraints the chairman asked any other proponents to stand and introduce themselves. The following persons spoke in favor of the bill:
Lisa Payne, Christine Bautista, Tammy Smith.

The chairman recognized Senator Hager who said he had spoken with a person from the Martinsdale Colony and indicated their colony was in favor of the bill. He also said they had a meeting with other colonies in the state and they indicated their support for the bill.

Opponents' Testimony:

The first opponent to testify was Peter Burleigh, representing the Montana Medical Association. See Exhibit #6 for a copy of his testimony.

The second opponent to testify was Paulette Kohman, executive director of the Montana Council for Maternal and Child Health. See Exhibit #7 for a copy of her testimony.

The third opponent to testify was R.D. Marks, Family Practicioner from Missoula. See Exhibit #8 for a copy of his testimony. He encouraged the legislature to end this issue once and for all.

The fourth witness to testify in opposition was Marietta Cross, a registered nurse from Missoula. See Exhibit #9 for a copy of her remarks.

The fifth witness to testify in opposition was Mike Stephen, representing the Montana Nurses Association. He said the Association continues to oppose licensure of direct-entry midwives. He said this bill does address licensing and regulation. If it passes it should have strong and direct regulation.

The sixth witness to testify in opposition was Jim Aherns, representing the Montana Hospital Association. See Exhibit #10 for a copy of his testimony.

The following opponents submitted written testimony:
Laura Glover, see Exhibit #11 for a copy of her testimony;
Betty Hildago, see Exhibit #12 for a copy of her testimony;
Mary Hackett, see Exhibit #13 for a copy of her testimony;
Alla Brooks, see Exhibit #14 for a copy of her testimony.

Questions From Committee Members:

The chairman recognized Senator Pipinich who asked Mona Jamison how long she worked on the bill with Dr. Nelson.

Ms. Jamison said from October 1 through the present. She said about four months. She was handed the adverse amendments at the hearing. She said Senator Svocek will offer a number of amendments which they accept and find reasonable.

Senator Pipinich asked about the Montana Medical Association (MMA) first being proponents of the bill then becoming opponents.

Ms. Jamison said she thinks there is internal fighting within the organization on the bill. Some physicians are taking the position of not liking midwifery but wanting it regulated. Others are still opposing it. She said Dr. Nelson testified in support. She said MMA is confused about the bill.

The chairman recognized Senator Hager who asked Mona Jamison about Mr. Marks statement referencing Ms. Jamison as suspect because she wrote the bill. He asked who else assisted with drafting of the bill.

Ms. Jamison said she worked with the Legislative Council, examined other statutes, worked with Eddy McClure. She said she considers this an area of expertise. She said when she worked for another governor where she handled all phases of legislation. She said the bill reflects what must be in a licensing bill under Title 37.

The chairman recognized Senator Towe who asked Mona Jamison about Section 11, Prescription Drugs. He asked for a point of clarification. He also asked about Section 14.

Mona Jamison responded by saying that the intent is, except for those written by a physician on prescription, no other drugs can be administered. She said the sponsor of the bill asked about unbecoming conduct. She said she copied boiler plate on that section.

The chairman recognized Senator Franklin who asked Dolly Browder what her feeling was about lay midwives who would not participate in traditional licensure.

Ms. Browder said she thinks all direct-entry midwives that are practicing in the state will be compelled to be licensed. She said there are some that will be grandmothered in and others who have not attended hundreds of births that are looking to finish that process of application. She said Washington state has an excellent program. They have worked with the non-licensed midwives to bring them into the fold. She said she thinks the non-compliance numbers are very small.

Closing by Sponsor:

The chairman recognized Senator Svrcek for closing remarks. He said with regards to the board, the composition is no different that any other board that licenses practitioners in Montana. All health practicioner boards have a preponderance membership of practitioners. Some remarks centered about mortality. He said the infant mortality rate in the United States is higher than several European nations that have midwifery built into the birth process. The practice of midwifery in Europe has decreased infant mortality, according to many studies. He said the United Nations has found that the practice of midwifery has decreased infant mortality. He said informed consent borders on insulting the mother and father, a choice they are making. The bill does not lower the standard of care from the status quo. Rather the bill establishes a standard of care for lay midwifery that is higher than present law. With regard to the 50-mile limitation, he said there was no way he could support that amendment. He said he represents a rural area, where hospitals are further than 50 miles. He said these people are served by lay mid-wives. He said he appreciates the opportunity to be invited to executive session.

HEARING ON SENATE BILL 168

Presentation and Opening Statement by Sponsor:

The chairman recognized Senator Steve Doherty who said his bill will specifically allow cloth diapers in daycare centers in Montana. This will not mandate the use of cloth diapers, simply remove the prohibition. The compelling reasons for doing this include his brother who has a child, they would like to continue to use cloth diapers in a daycare facility. He said this bill will reduce discrimination, is pro-child care because cloth diapers are cheaper, is pro-environment and proponents will testify in accordance. He said the bill is also pro-business because the cloth diaper business is needed in Montana. Other states such as Oregon, Washington, Vermont and Maine have established similar laws. In Missoula there is a limited waiver to allow cloth diapers.

Proponents' Testimony:

The chairman called upon the first witness to testify in favor of SB 168. Linda Lee, representing the Montana Audubon Legislative Fund. See Exhibit # 14 for a copy of her remarks.

The second witness to testify in favor was Caroline Brinkley a physician with the Missoula County Health department and a mother with two children. See Exhibit #15 for a copy of her testimony. Many disposable diapers are sources of park and highway litter. Cloth diapers are used about 200 times before being retired as lint free rags.

Exhibit #1
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6th day of February, 1991.

Name: Dolly Browder

Address: 200 Woodworth
Missoula, MT 59801

Telephone Number: (406) 543-6826

Representing whom?

Montana Midwifery Association

Appearing on which proposal?

SB 172

Do you: Support? X Amend?____ Oppose?____

Comments:

MMA supports the bill as written
& license direct entry midwives.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Ex. 1b
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of February, 1991.

Name: Mary Stranahan

Address: Star Rt, Box 90
Dixon, MT.

Telephone Number: 246-3510

Representing whom?

Self

Appearing on which proposal?

Senate bill 172

Do you: Support? ✓ Amend?____ Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Ex. 1a
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6th day of February, 1991.

Name: Mona Jamison

Address: 610 Touchstone Ct. - Dome Block, 42 Helena, MT
Helena

Telephone Number: 442-5581

Representing whom?

Montana Midwifery Association

Appearing on which proposal?

SB 172

Do you: Support? ✓ Amend?____ Oppose?____

Comments:

Support ~~reasonable~~ reasonable + non-punitive regulation of direct-entry midwifery.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 2-6-91
BILL NO. SB 172

p.j. hennessy, m.d.
243 NORTH AVE. EAST
MISSOULA, MT 59801
(406) 721-8849

Testimony for SB 172: Direct Entry Midwifery Licensing
Senate Public Health Committee
6 February 1991

I am a physician with a special interest in the health of women and children and I have a Master's in Public Health.

As the Committee is well aware, the loss of obstetric providers and the closing of many rural hospitals has reached crisis proportions in some Montana counties. This situation has set the scene for a potential public health nightmare; that some women may be forced to deliver babies without a birth attendant.

Midwifery in Montana has stepped in where physicians malpractice liability has made them fear to tread. Midwives are helping Montana women have safe births

Currently those who have been called to serve as midwives undertake a self imposed educational regimen. SB 172 will serve to strenghthen the performance of those already attending births. It will also provide the means to continue the learning process through a rigorous standardized format.

This piece of legislation will provide for the health and safety of Montana's future citizens and their mothers. I strongly urge you to support it!

PJHennessy M.D.

Exhibit # 2
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of FEB., 1991.

Name: PAMELA ROSE SRM/EMT

Address: MOUNTAIN FAMILY CENTER BOX 10
GERALDINE, MT 59446

Telephone Number: 406 737 4519

Representing whom?
MONTANA MIDWIFERY ASSOCIATION

Appearing on which proposal?
SB172

Do you: Support? ✓ Amend?____ Oppose?____

Comments:
THE RURAL AREAS OF MT ARE IN AN OBSTETRICAL CRISIS, MIDWIFERY HELPS TO FILL THE GAP IN BIRTH SERVICES FOR PEOPLE IN THESE AREAS.

I HAVE BEEN IN THE PRACTICE OF MIDWIFERY SINCE 1979 AND SERVE 150 MILE RADIUS OF RURAL AG. MT. THE 50 MILE LIMIT IS NOT PRACTICAL IN MT WHERE SOME MUST TRAVEL 100 M TO SHOP. PLEASE THE 50 MILE LIMIT TO THE NEW HAMPSHIRE MIDWIVES THAT IT WAS ORIGINALLY ADOPTED FOR. LICENSING MIDWIFERY WILL ASSURE CONSUMERS HIGH SKILL + QUALITY BIRTH SERVICES.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Pam Rose

Pamela Rose
Mountain Family Center
P.O. Box 10
Geraldine, MT 59446

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2-6-91
BILL NO. SB 172.

EXPOSITORY:

Quality prenatal care is the core of my practice.

90% of my patients live in remote rural ag communities located in the sparsely populated regions of north central and north eastern Montana.

Before Midwifery Services prenatal care for these people meant many miles of travel and expense....for a very brief visit with thier physician.

For these people childbirth education classes are not a practicality because of the distances that must be traveled to attend them.

Summerfallowing, seeding, harvest, haying and calving are priorities that cannot be neglected and the financial rewards for thier labor is slim in contrast to the expense. Most of the people that I serve are not in the financial position to purchase Medical Insurance and yet they are not destitute requiring welfare and receiving medical coverage from the government.

I bring prenatal care, childbirth education, homebirth services and postpartum care to thier homes, at thier convenience, for an affordable fee. I screen and refer those who need specialized care to the appropriate physicians.

I live and work in the portion of the state that cannot seem to entice Physicians to live and practice in our small economically depressed rural communities. Our small community hospitals that in the past provided Birth Services have one by one closed thier doors to laboring women.

The Licensing of the Special Skills and Training riquired for the Art and Practice of Midwifery will assure the people obtaining these services of the high quality of thier care.

Thank You!

TO: DO NOT LIMIT THE MILES THAT A MIDWIFE MAY SERVE. MT'S RURAL AG COMMUNITIES WOULD BE DEPRIVED OF BIRTH SERVICES. BY LIMITING MIDWIVES TO 50 MILES, MANY COMMUNITIES MUST TRAVEL 100 TO LARGER COMMUNITIES. I IMMEDIATE MIDWIVES ARE WHO THIS LIMITATION

Exhibit # 5
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6th day of February, 1991.

Name: Pamela Shore RN JD

Address: 920 Evans, Missoula, MT 59801

Telephone Number: (406) 721-1391 or (406) 728-0566 work number

Representing whom?

self

Appearing on which proposal?

SB 172

Do you: Support? X Amend?____ Oppose?____

Comments:

(1) I am a nurse-attorney. I have had 2 homebirths Attended by a midwife. They were safe and the first child was born in a rural setting.

(2) As an attorney I support the states effort to assure continuing safety for home birth mothers. SB 172 is a well thought out conglomeration of other states efforts to regulate Midwifery.

(3) Rural areas are underserved by our MD population. Midwifery can and does help bridge this gap by providing low cost, safe assistance to those ~~how~~ who birth at home.

(4) SB 172 is a safe and cost effective way to deliver quality services across MT

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Exhibit 3 is the original newspaper article that is photocopied as Exhibit 4. The original is stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

Exhibit # 4
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6th day of February, 1991.

Name: Nancy Clark Keener

Address: 911 Rimini Missoula 59801

Telephone Number: 7214901

Representing whom?

MT. Midwifery Assoc.

Appearing on which proposal?

SB. #172

Do you: Support? ✓ Amend?____ Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Missoulian
MONDAY
February 4, 1991

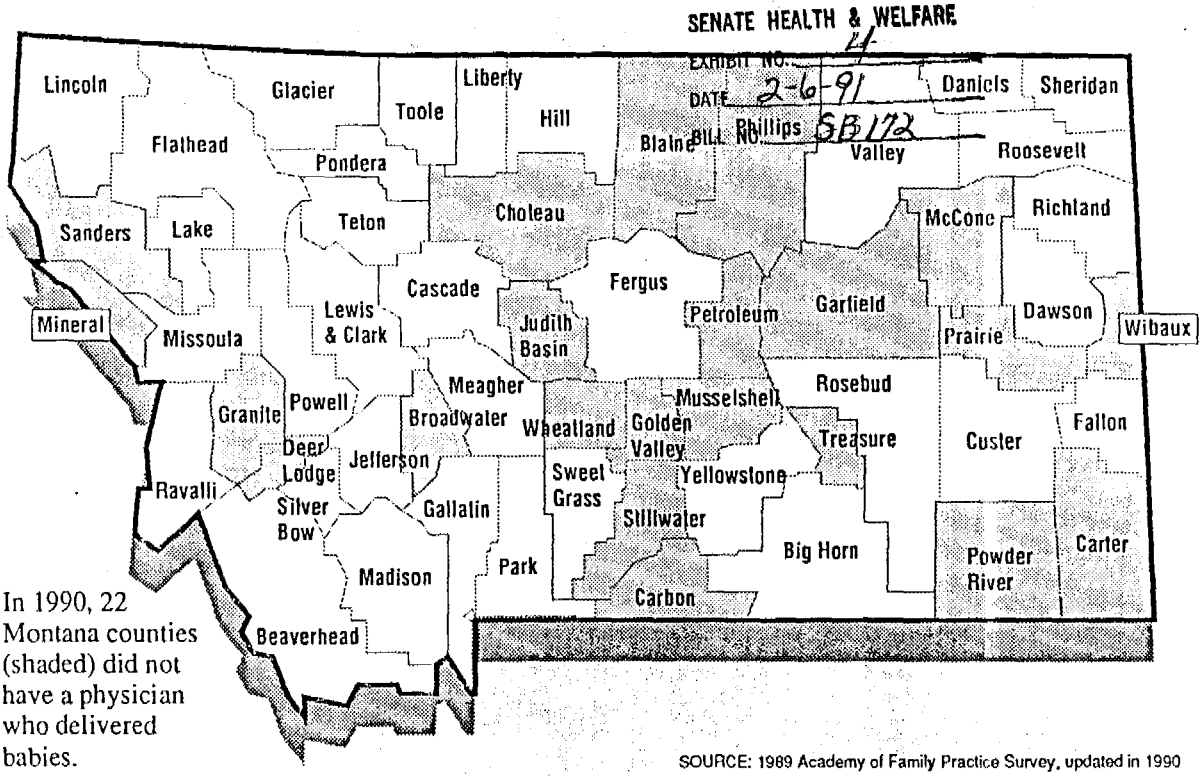
FAMILIES B-1

People in education.....B-2

#6.

Montana counties without physicians who deliver babies

SENATE HEALTH & WELFARE
EXHIBIT NO. 4
DATE 2-6-91
BILL NO. SB 172



In 1990, 22 Montana counties (shaded) did not have a physician who delivered babies.

SOURCE: 1989 Academy of Family Practice Survey, updated in 1990

Delivering babes in the woods

State ponders problems of rural perinatal care

By BILL LOMBARDI
Missoulian State Bureau

HELENA — In 1990, a governor's health-care advisory panel identified 22 Montana counties without physicians who deliver babies.

"Because of the declining number of physicians in Montana in the past decade, our ability to provide adequate perinatal care to women and infants in rural areas has significantly eroded," says the panel's report on Health Care for Montanans.

High malpractice insurance premiums and inadequate Medicaid reimbursement rates paid to obstetricians and pediatricians have sparked a crisis of sorts in rural as well as urban areas. Poor women, especially, are being denied equal access to appropriate prenatal, delivery and postpartum health services, say lawmakers and health officials.

"The trauma is obvious," says Sen. Mike Halligan, D-Missoula.

He is sponsoring a bill that would give rural and urban baby doctors a state income tax credit to encourage them to keep delivering services to Medicaid recipients.

The price tag: $897,000 a year.

"The cost of this obviously is a lot," Halligan recently told the Senate Taxation Committee. "I'm not so sure we can afford that."

Meanwhile, taxpayers, for instance, are being asked to help pick up the costs associated with low-birthweight infants of Medicaid recipients because their mothers may not have received prenatal care and advice, officials and physicians say.

In fiscal 1988, 129 infants cost $4.2 million in Medicaid funding for delivery and the first year of care. Most were low-birthweight infants. Their cost was 51 percent of the total $8.3 million spent, though they represented only 4 percent of the 3,248 Medicaid deliveries, according to the state.

In fiscal 1989, the state recorded 2,571 Medicaid deliveries, or 22.5 percent of the state's average 11,412 deliveries per year.

The Stephens administration has proposed an ambitious health-care package for the 1991 Legislature, which, among other things, calls for increasing Medicaid reimbursement rates for obstetrical procedures to 90 percent of the average customary charge.

The Medicaid reimbursement for a delivery now is $755, compared with an average charge of $1,369. Some doctors complain the current rate doesn't even cover their overhead costs, much less the services they render.

"They're losing money on every delivery with the rate structure we have," says Nancy Ellery, chief of the state Medicaid Services Division.

The governor's "Kids Count" proposal, which requests $3.3 million from the state general fund, also calls for increasing Medicaid reimbursement rates to pediatricians to 80 percent of the average customary charge.

The federal Health Care Financing Administration has not yet approved Montana's Medicaid program for obstetrical and pediatric payments. Disapproval could jeopardize federal financial participation in the program and worsen an already critical situation, state officials note.

Federal regulations require the state to pay reasonable and adequate reimbursement rates that ensure Medicaid recipients can get access that is available to the general population.

"This is an equal access issue," Ellery says.

Since 1986 state officials have watched almost helplessly as 30 percent of the physicians who previously delivered babies dropped that service because of insurance and reimbursement problems, she notes.

Meanwhile, more low-income Montanans are becoming eligible for Medicaid benefits but can't find health-care services, Ellery says.

Some pregnant women, notes Dick Brown of the Montana Hospital Association, must drive 100 miles or more to obtain services.

While the Montana Medical Association and Montana Hospital Association support Halligan's tax measure aimed at encouraging physicians to help poor women and infants, they would rather see Medicaid reimbursement rates jacked up.

"The problem's getting worse each session," says Jerry Loendorf, a lobbyist for the Montana Medical Association.

OVER

A DOCTOR'S STORY

90-hour week is the norm

By BILL LOMBARDI
Missoulian State Bureau

HELENA — Dr. Jim Ashcraft of Sidney is swamped with work.

A family physician in extreme eastern Montana, he is the only doctor who delivers babies in a 50-mile radius. Sidney's only obstetrician was called up to serve in the Persian Gulf war.

"I'm the guy that's delivering babies," Ashcraft says, noting he's putting in a 90-hour work week to maintain his practice.

Although Medicaid reimburses only about half the costs for each delivery, he says he hasn't turned away pregnant women or decided to stop helping the poor.

Some low-income patients who don't qualify for government medical benefits and can't afford to pay him have turned to barter, paying Ashcraft in-kind with hams, chickens and firewood.

"The amount that Medicaid pays doesn't pay my overhead," Ashcraft says. "It's just that simple. I would be better off not to deliver them. But I'm out here in the middle of nowhere; so where do they go?"

He says he can feel the pinch of high malpractice insurance premiums for delivering babies and low state Medicaid reimbursement rates. To help pay for losses, the medical profession generally transfers the costs to private insurers, Ashcraft notes. That generally helps drive up health-care costs, officials have noted.

"If I didn't do obstetrics, my premium would be $7,000 a year," Ashcraft notes. In 1989, his malpractice insurance premium was about $21,000 because he delivered babies.

Ashcraft, who last year served on Gov. Stan Stephens' Health Care Services Availability Advisory Council, says lawmakers in previous sessions failed to deliver a prescription to the state's health-care problems.

He says he supports "in concept" the Stephens administration's plans to boost Medicaid reimbursement rates and a proposal to provide prenatal care to mothers to cut the number of at-risk infants and associated societal costs.

"Pay me what it costs," he says flatly. "If I want to cut back, I would tell Medicaid to go take a hike. But I'm also an optimist and think we will find a way. You've got to pay up front or you pay more later."

State officials must help stanch the flow of physicians fleeing the delivery room and those refusing to give care to the poor, Ashcraft adds.

"We're not going to get the people back who stopped," he says. "I know I can't last forever. I just don't have any more time. My wife would like to see me home some days.

"If our (obstetrician) doesn't come back, I'll probably deliver 150 babies," Ashcraft says. "That's a large number in Montana. The average family physician delivers about 30."

Exhibit # 4a
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 2/6/91 day of FEB, 1991.

Name: LARRY PETERMAN

Address: 2136 COLLINS LANE

Telephone Number: 728-2643

Representing whom?

SELF

Appearing on which proposal?

SB172

Do you: Support? X Amend?____ Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Exhibit # 46
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6th day of February, 1991.

Name: Diane Spizzirri

Address: HCR 81, Box 9
Shawmut, MT 59078

Telephone Number: 632-4229

Representing whom?
self

Appearing on which proposal?
SB 172

Do you: Support? ✓ Amend?____ Oppose?____

Comments:

My husband & I live 1½ hrs away from the nearest hospital which delivers babies. My extremely short labor/delivery time made it necessary to have a homebirth with a midwife in attendance. There were no licensing regulations to rely on to help us make a wise choice, so I had to do a great deal of research & fortunately I was qualified to make this choice because of my BS in zoology in developmental biology & reproductive physiology. Others may not be as qualified to make that choice. Our midwife was extremely professional & competent. The care I received was excellent. Licensing is necessary to assure everyone can choose a qualified midwife. It will also provide the respect & credit due to these midwives who have always maintained the highest standards. Thank you.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Exhibit # 4c
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of Feb., 1991.

Name: Connie Rubens

Address: RR, Box 41
Carter MT 59420

Telephone Number: 452-8021

Representing whom?
~~Montana Midwives~~ self

Appearing on which proposal?
SB-172

Do you: Support? X Amend?____ Oppose?____

Comments:

My baby was birthed through a midwife. It was a homebirth and all went well. My midwife was very skilled. She came regularly for prenatal care and a couple times after the birth. My husband and I would recommend to anyone expecting a baby to try a midwife. If we decide to have another baby, we would have a midwife again. We choosed a midwife because we wanted a natural birth and it was affordable. I, and my baby, recieved expert and personal care through a midwife.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Exhibit # 4a
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6th day of Feb, 1991.

Name: Kim Ronshaugen

Address: 318 14th St S
Great Falls MT

Telephone Number: 452 2570

Representing whom?
self

Appearing on which proposal?
SB 172 MT Midwifes

Do you: Support? ✓ Amend?____ Oppose?____

Comments:

fell thru cracks in FL. 5 mos preg - Dr wouldnt give care
Good quality care w/ midwives Real Need.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Exhibit # 5
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of February, 1991.

Name: VAN KIRKE NELSON M.D.

Address: 210, SUNNYVIEW LANE
KALISPELL, MONTANA

Telephone Number: (406) 752-5260

Representing whom?

VAN KIRKE NELSON

Appearing on which proposal?

SJ 172

Do you: Support? — Amend?____ Oppose?____

Comments:

support licensure by modality

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

PROPOSED AMENDMENTDS SB 172 LAY MIDWIFERY PRESENTED BY VAN KIRKE NELSON, M.D. TO PUBLIC HEALTH, WELFATE AND SAFETY

Dorothy Eck, Chairman
Eve Franklin, Vice Chairman
Jim Burnett
Tom Hager
Judy Jacobson
Bob Pipinich
David Rye
Tom Towe

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 2-6-91
BILL NO. SB 172

Exhibit 5 also contains a proposed ordinance on lay midwifery for the city of El Paso. The original is stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

Under statement of intent to review regulations promulgated by the State of New Hampshire, New Mexico and El Paso, Texas.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section section 3 Definitions - Direct entry midwife - a lay person provider.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section section 4 attends or assists a woman during pregnancy, labor, natural childbirth or the post partum period <u>where no risk providers have been identified</u>.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section section 4 attends or assists a woman during pregnancy, labor, natural childbirth or the post partum period <u>where no risk providers have been identified</u>.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section section board composition change to two lay midwifes, two physicians, (an obstetrician, and pediatrician) one certified nurse midwife and a member of the public

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section - section 7 does not constitute training or supervision by the hospital and shall not be a requirement for a Montana hospital to provide.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section section 9 the provisional license is valid only after verification of deliveries attended and verification of passing grade on examination.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section section 9 an apprentice direct entry midwife license is valid for only one year and must be renewed annually with a limit of three renewals.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB172

New section Section 10

4. An applicant who fails to achieve a passing exam will not engage in the practice of midwifery.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section section 11 administration prescription drugs prohibited. Delete Xylocaine.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section 17

(6) as may otherwise be required by law. Law should state that in addition to filing of birth certificates with the DHES that any adverse outcomes, hospital or physician referrals be mandatorily reported to the DHES.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

New section section 18

(2) Informed consent will be evidenced by a written statement.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

New section section 20

(2) screening for hepatitis B, serology, rubella and Rh

(7) Rh screening of infant if Rh negative mother and if rhogam indicated referral for same.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

The practice of direct entry midwifery will not be practiced in areas greater than fifty miles from a hospital with cesearean section capability.

Reason for above: to allow direct entry midwifer anywhere is totally out of the question. In convention medicine, convention obstetrics, if someone goes into the labor they proceed immediately to the source of their care qwith labor and delivery accomplished in that facility equipped to do whatever is necessary for a healthy mother and a healthy infant. What of the lay midwife who provides care in a rural, remote area over several hours even greater than twenty-four hours, and then something happens - what chance does the mother or infant have if reasonably ready access to care by a medical provider and hospital are not available.

THe majority of those providiong lay midwifery are inurban areas. For the one or two providers of lay midwifery services that may be effected is it worth the risk to the mothers and infants to whom they provide care because they choose to provide it in a remote area.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

If in any three years of a five year period the neonatal mortality rates for lay midwife directed or attended deliveries exceeds by 50% the infant neonatal mortality of infants delivered in Montana hospitals, or if the total neonatal mortality rate at the end of five years for lay midwife directed or attended deliveries exceeds by 50% that of the neonatal mortality rate in Montana hospitals, the licensing of midwifery in Montana will sunset and the practice declared illegal.

Van Kirke Nelson, M.D.

Exhibit # 5
2-6-91 SB 172

Proposed amendment SB 172

A Montana county, through its health department, can strengthen rules and regulations promolgated by state midwifery licensing board so long as any changes in requirements or regulations meet the minimums established by state law and the licensing board.

Van Kirke Nelson, M.D.

Exhibit # 6
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 4 day of Feb, 1991.

Name: Peter Burleigh

Address: Great Falls Clinic PO Box 5012
Great Falls MT 59403

Telephone Number: 454 2171

Representing whom?
MMA - Self

Appearing on which proposal?
Midwife SB 172

Do you: Support?____ Amend?____ Oppose? X

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Dr Burleigh

Dr. Burlaiwrlois

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 2-6-91
BILL NO. SB 172

O B S T E T R I C A L M O R T A L I T Y I M P R O V E M E N T

U . S . S T A T I S T I C S

1915

50% of deliveries by midwives
<25% in hospitals

Maternal mortality - 780/100,000
Perinatal mortality - 124/1,000

1940

60% in hospitals
Obstetrical specialists in larger cities

Maternal mortality - 380/100,000
Perinatal mortality - 50/1,000

1970

95% in hospitals
Most deliveries by obstetricians
Pediatricians care for high-risk newborn

Maternal mortality - 21/100,000
Perinatal mortality - 29/1,000

1985

99% in hospitals
Intensive prenatal care & neonatal nurseries

Maternal mortality - 7/100,000
Perinatal mortality - 15/100,000

Exhibit #69
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of Feb., 1991.

Name: Lisa Payne

Address: PO Box 1099
Helena, MT 59624

Telephone Number: 449-7917

Representing whom?
MT Women's Lobby

Appearing on which proposal?
SB 168 & SB 172

Do you: Support? X Amend?____ Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

SENATE HEALTH & WELFARE
EXHIBIT NO. 7
DATE 2-6-91
BILL NO. SB 172

Montana Council for Maternal and Child Health

The Voice of the Next Generation
in Montana's State Capitol

2030 11th Ave., Suite 10 Helena, MT 59601 (406) 443-1674

TESTIMONY FOR THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
OPPOSING SB 172, LICENSURE OF MIDWIVES
Date: February 6, 1991

The Montana Council for Maternal and Child Health, a non-profit public policy research, education, and advocacy organization, has studied the implications of SB 172 on maternal and child health in Montana, and opposes its passage. Our conclusions are based on historical data on home births, current trends in access to health care, and considerations of public policy. While the bill may be improved with substantial amendment, in its current form SB 172 actually endangers the health of pregnant women and unborn children in Montana, particularly in medically underserved rural areas. We urge the committee to reject this bill, and consider instead other means to improve both the quality and availability of prenatal care and childbirth services for pregnant women and their families in Montana.

HISTORICAL ROLE OF LAY MIDWIVES IN MONTANA:

Our great grandparents had no choice about where to give birth. The home was the only location available. Many travelled long distances to give birth in a relative or friend's home where a doctor was nearby, and most would have given their eyeteeth to deliver in a modern hospital. The romance of home delivery is clouded by the fact that many of its practitioners ended up in lonely homestead graves, side by side with their babies.

Since hospital maternity care became routinely available, statistics from the state Bureau of Vital Statistics show that the number of out-of-hospital births has not been large. In 1954, the first year for which statistics on hospital vs out-of-hospital births are available, .6% of births were midwife-assisted. This percentage did not change substantially until the 1970's, when the number of out-of-hospital, non-physician assisted births slowly began to increase.

As these vital statistics show, the fetal, infant, and maternal death rates have dropped significantly since 1915, but seem to have reached a minimum in the late 1980s. We notice an increase in 1989 infant death rates to the highest level since 1980. Whether this is related to an increase in out-of-hospital births, reflected in the steady percentage increase in out-of-hospital births, is unclear. It may just be a statistical blip which will be corrected when the 1990 figures are computed. We do know that, nationwide, the best preventive measure to decrease infant mortality is prenatal care, given by a physician or certified nurse-midwife.

YEAR	TOTAL BIRTHS	% MID-WIFE	FETAL DTH /1000	INF. DTH /1000	MAT. DTH /100,000
1915	11,132			73.3	817
1920	11,862			72.7	876
1925	10,302		33.3	70.5	805.7
1930	10,004		28.6	56.9	669.7
1935	10,029		23.1	60.0	518.5
1940	11,468		18.8	46.0	340.1
1945	10,601		17.4	34.2	160.4
1950	15,592		14.9	28.3	128.3
1955	17,454	0.6	12.7	24.8	28.6
1960	17,448	0.5	10.9	24.9	28.7
1965	13,641	0.6	13.0	24.8	14.7
1970	12,622	0.4	11.1	21.5	23.8
1975	12,070	0.5	9.3	15.5	24.9
1980	14,208	1.1	7.3	12.4	14.1
1985	13,497	1.7	7.1	10.3	0
1986	12,728	1.7	7.5	9.6	15.7
1987	12,239	1.9	7.8	9.8	0
1988	11,682	2.1	7.9	8.6	8.6
1989	11,667	2.4	7.5	11.3	0

Clearly, maternity care in Montana is affected by several limitations. Some 20% of Montanans are uninsured, health care costs and health insurance premiums have risen, and many rural areas have lost obstetrical services over the past decade. The war in the Gulf now promises to drain our remaining supply of health care workers, aggravating the shortage.

But the licensing of lay midwives as providers of primary care for pregnant women is not a solution. The solution is to develop opportunities and training programs for certified nurse-midwives and other established and professionally qualified practitioners. Certified nurse-midwives in Montana provide some of the best maternity care in the state. The Elizabeth Seton Clinic in Billings has had to turn away women who are seeking exactly what the clients of lay midwives want: a human touch, an educational approach, and a minimum of intrusive machinery. They are trained to the Masters degree level, and they work within the existing health care delivery system to insure that emergency care and high-tech interventions are available when the need arises.

Specific issues with SB 172:

I. Board composition:

A lay midwife, no matter how earnest is her pursuit of excellent care, clearly does not have the depth of training and experience to deal adequately with some complications of the normal birth process. And to practice in the home, many miles from hospital care, only multiplies the problem. The world's greatest obstetrician would be helpless to save the life of a mother or baby in many instances without the steel and chrome appliances and electronic gadgetry of a hospital. To aggravate the situation, the proponents of SB 172, rather than tapping the resources of trained obstetricians and certified nurse-midwives, have consciously and vigorously opposed including them in full partnership on their licensing board.

One result of this distancing from the medical community is that SB 172 has become a medical text. It is an earnest effort to have the legislature make all the critical decisions. The purpose of creating a licensing board is to delegate this responsibility to a competent group. But if the proposed licensing board is not competent to direct and regulate the practice of lay midwifery, how can the legislature -- ranchers, teachers, lawyers, citizens who gather together only five times in a decade? Are the midwives to return to the legislature each session to update the law and include new diagnostic tests, new recommendations, new standards of care? What if they don't? SB 172 will become a dinosaur, and women will be ill-served under obsolete rules.

We propose that the lay midwifery board should include persons who have the expertise to make detailed medical regulations, and that process of rulemaking be left to them. **Our suggestion is that the board include an obstetrician, a pediatrician, and a certified nurse-midwife.** All of these, by training and experience, have extensive knowledge of the medical aspects of childbirth and can provide the necessary guidance to the lay midwives.

II. Education Provisions:

The education portion of the bill does not specify the nature of the education required for licensure. The content which is specified may be covered in any thing from a weekend seminar to a three-year curriculum of study, such as is required in Washington state.

We suggest the law require a minimum number of semester hours of study, at an institution which has met some form of accreditation for the preparation of lay midwives for practice.

III Informed Consent:

We propose two amendments to improve the informed consent described in Section 18 of the bill. The first is to specify that the informed consent contain, on page 15, line 3, the following language:

"(a) a description of the risks of home birth, primarily those conditions which can arise during delivery and may endanger the mother or the child without the immediate availability of hospital services."

The bill does not require this and we feel that it is the essence of informed consent to acknowledge the risks of the choice involved.

The second is to specify that the parents (including the father if he is involved in the decision-making) of the unborn child acknowledge the risks to the child of home birth and distance from medical care, and their acceptance of that risk on his or her behalf. The amendment would be to Section 18, page 14, line 21, inserting after the word "woman" the following language: "and from the mother and father (if he is participating in the decision-making) of the unborn child, acknowledging their acceptance of risk on behalf of the child."

III. Confidentiality:

We propose an amendment to the confidentiality provisions of the bill (Section 17, page 14, line 17, to add an exception, "(6) when the lay midwife client is seeking emergency medical treatment and history is requested by the attending medical professional.

(67)"

This would mean that a midwife could not withhold information in an emergency room admission, for example.

Exhibit # 7
2-6-91 SB 172

IV. Mandatory referral for prenatal care:

We propose an amendment to section 21, page 16, lines 22-24, to state that a licensed lay midwife "~~is encouraged to advise~~ shall recommend that all women accepted for midwifery care consult with a physician at least twice during the pregnancy." The proposed bill merely "encourages" the midwife to recommend this. This amendment would make section 21 consistent with the provisions of section 21, requiring a lay midwife to recommend various screening tests.

SUMMARY:

The Montana Council for Maternal and Child Health supports any reasonable approach to providing prenatal care and maternity services to Montana's pregnant women. We recognize that some mothers and fathers may choose to avoid hospital birth, and we support measures to make home birth safer. We do not, however, support licensure of lay midwives to provide medical care, encouraging women to give birth in isolation from trained medical staff and technological intervention, without adequate prenatal care. No lay practitioner can substitute for trained health care workers.

Respectfully Submitted,

Paulette Kohman

Paulette Kohman
Executive Director

Exhibit # 7
2-6-91 SB 172

(21)

Exhibit #8
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of Feb, 1991.

Name: R.D. Marks, M.D

Address: 2931 Fort Missoula Rd

Missoula MT 59801

Telephone Number: 542 1232

Representing whom?

Self

Appearing on which proposal?

SB 172

Do you: Support?____ Amend? X Oppose? X

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

FAMILY PRACTICE MISSOULA

631 West Alder
Missoula, Montana 59802
Telephone: 721-1850

DONALD R. NEVIN, M.D.
JUDY McDONALD, M.D.
ERIC J. KRESS, M.D.
TERENCE CALDERWOOD, M.D.

Diplomates, American
Board of Family Practice

February 5, 1991

SENATE HEALTH & WELFARE
EXHIBIT NO. 8
DATE 2-6-91
BILL NO. SB 172

Montana State Senate
Public Health Committee
State Capitol
Helena, Montana

Dear Senators:

The time period surrounding human birth is a period of high risk for both the mother and infant. No matter how much we all might wish that were not so, that remains the central fact of human birth. We feel it is the responsibility of your committee to keep that fact foremost in your mind as you consider what should happen with Senate Bill 172. At this point, it is clear that lay midwifery is going to be legalized in Montana and we think we should take great care in making the services that will be delivered to these women as safe as possible for Montana citizens.

We feel that anyone providing perinatal services should be educated in an accredited school and that this needs to be a requirement for licensing. The education should be structured and of sufficient duration to allow comprehensive learning. It should not be acquired through an apprenticeship. The content of the education must develop sufficient skills for infant resuscitation. We would urge your committee to examine the programs for infant and child resuscitation developed through the American Heart Association or through several of the nation's pediatric programs. Lay midwives should be well versed in these techniques if they are to be able to provide sufficient safety for home births. This requires learning the use of complex equipment and designing a delivery system which has this equipment available at the time of birth.

Since lay midwives will provide health care, they should be a part of the larger health care community. At this time, we would recommend that their board should include a physician who is a member of the American College of Obstetricians and Gynecologists. As family practitioners, we often rely up on the more extensive training of our obstetric colleagues. We feel that the American College of

Exhibit # 8
2-6-91 SB 172

Obstetricians and Gynecologists has a proven record of concern for the safety of pregnant American women and a board certified obstetrician would lend a measure of safety to this board. We also recommend including a pediatrician and a nurse midwife. The path to integrating lay midwivery into our health care community is going to be a rocky one at best and will be best accomplished if training and licensing becomes respectable in the eyes of those who are currently providing health care to pregnant women and their infants. Thank you for allowing us to register our opinions.

Sincerely,

Judy McDonald

Judy McDonald, M. D.

Eric Kress

Eric J. Kress, M. D.

JM/ms

R.D. MARKS, M.D.
Family Practice

Missoula Community Physicians Center #2
2831 Fort Missoula Road
Missoula, MT 59801 • Office Phone 542-1232

Exhibit # 8
2-6-91 SB 172

February 6, 1991

To the Members of the Senate Committee on Public Health and Welfare:

I rise to speak in opposition to Senate Bill 172.

Let it first be clear that I am not opposed to the licensing of lay-midwives. I feel very strongly that if the legislature deems it appropriate to approve of home deliveries under the supervision of a lay-midwife, then the legislature must also assure that there is some quality control involved in determining who is licensed to perform these functions. A licensing act is the obvious method by which to do this; however, Senate Bill 172 falls far short of this objective in several areas.

Before I go on to discuss the bill itself however, let me remind the members of this committee that the medical profession sees home birth as a dangerous option and by condoning it, the legislature has,in fact, contradicted itself. While on one hand you have supported projects that will lower the perinatal morbidity and mortality, on the other hand you have given approval to a practice that will cause an increase in these problems.

Senate Bill 172 is a bill written by those who support the practice of lay-midwifery and home birthing. It is therefore designed for their self interest. That fact alone should make you look at the provisions of this bill very carefully because those interests are not necessarily in the best interest of the public's health and welfare.

An overall objection that I have with this bill is that it gets into many small details of the practice of lay midwifery to the extent that those details which are usually left up to a licensing board are going to be statutory regulations. You, as legislators, don't have the time to get full testimony and make educated decisions on each of the important "practice parameters" that are outlined in this bill and I would therefore encourage you to amend this bill to give to the licensing board the responsibility of determining what the practice guidelines should be.

And speaking of boards, what kind of board is this to be? If you will look at Section 5 of this bill, it stipulates that this will be a five member board consisting only of persons who support the concept of lay midwifery. What kind of licensing board is it that in its design appears to be nothing more that a stamp of approval for this groups beliefs? If it is truly the intent of this bill to assure that only qualified people practice lay midwifery and to

promote the safety of home deliveries, would it not be more important to stipulate that a majority of the members of the board be experts in the field of obstetrics and pediatrics. I suggest to you that this board should be made up of a pediatrician, a physician who practices obstetrics, a certified nurse midwife, three lay midwives, and a member of the public chosen by consensus of the other six members.

Obviously, no matter what option you choose in this regard, there is going to be a great deal of administrative work on the part of the board and the Department of Commerce to facilitate the provisions of this bill. I seriously doubt that the license fee suggested in the proposal is adequate to cover these costs and the ongoing cost of the board. I would suggest that the license fee be adequate to cover all the related costs.

I find many specific problems with this proposal but due to the required brevity of this type of hearing, I will only address a few of the more serious concerns.

Section 7: The provisions for educational requirements are in many ways vague and in other aspects inadequate. As an example, it is my opinion that all of the subjects covered in paragraph 2 (a through h) are subjects that will require more that just a hap-hazard study of these topics. These are areas of major focus in all medically related disciplines and to suggest that an adequate understanding can be achieved by informal means is an error. Furthermore, the requirements for practical experience are far less than those required in either nurse midwife or obstetric training and to claim that this is enough to know how to handle all the problems that will present in an emergent fashion in the home birth situation is naive. Finally, there is no indication in this section as to who are qualified supervisors of this practical experience. Without good guidelines as to qualifications for the supervisor, this could amount to nothing more than the blind leading the blind.

Section 10: In paragraph 3 it states that a grade of 70% on the licensure exam will be deemed adequate for licensing. That indicates to me that someone can still do a safe job of delivering babies and not know 30% of what is going on. I bring up this point for two reasons: first, it shows that the legislature is not the place for this sort of licensing provision to be decided, and second to remind this committee that the are some concepts of the birthing process that cannot be optional and the provider of services needs to be 100% sure of how to handle certain situations.

Section 11: While this paragraph states that a lay midwife may administer certain medications after they have been prescribed by

a physician, there is no explanation as to how training for the administration of these drugs will occur nor is there any description of the relationship between the prescribing physician and the lay midwife. Could this be done from a physician from across the state of from another state. Furthermore, does any one of you, the members of this committee, know enough about the use, side effects, and potential toxicity of these drugs to say in a knowledgeable manner that its appropriate for a person with little training to administer these drugs? I have included in the written testimony before you material from the PDR which discusses the potential toxicity of this drug but let me paraphrase a portion "...Xylocaine...should be employed only by clinicians who are well versed in the management of dose related toxicity and other acute emergencies that may arise ..."

Section 12: The proposal states here that a lay midwife may perform and repair episiotomies. There is no delineation between a "simple" episiotomy and those more complexed. Does any member of this committee know enough about this to differentiate between a 2nd, 3rd, or 4th degree episiotomy, and do you think that the repair of a 4th degree episiotomy which involves the perineum, the muscles of the anal sphincter, and the rectal mucosa itself a simple procedure? How can you, if you are not understanding of the complexities of the problem, be asked to give approval for someone else to do this.

Are you satisfied to accept the assurances of the proponents of this proposal that this is no big deal? I disagree.

Finally, there are numerous references made to midwives licensed under this act as "professionals". A "professional," according to the dictionary, is someone who practices in a specialized field that requires advanced studies. Hardly do the people asking for licensure under this proposal meet the requirements of that definition and to call them professionals in the same context as nurses, surgical technicians, physicians, nurse midwives, attorneys, and accountants is a disservice to these true professionals. I would urge that that designation not be used in this proposal.

In summary then, this is a bill that addresses an important problem but attempts to do by statute what should be done administratively and is basically asking permission for inadequately trained people to supervise the inherent dangers that accompany home birthing. I suggest that this bill needs a lot of work before it can do what is intended and I would encourage you to not advance this bill for the consideration of the Senate until that work is completed.

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Consult PDR® Supplements for revisions

WARNINGS

XYLOCAINE INJECTIONS FOR INFILTRATION AND NERVE BLOCK SHOULD BE EMPLOYED ONLY BY CLINICIANS WHO ARE WELL VERSED IN DIAGNOSIS AND MANAGEMENT OF DOSE-RELATED TOXICITY AND OTHER ACUTE EMERGENCIES THAT MIGHT ARISE FROM THE BLOCK TO BE EMPLOYED AND THEN ONLY AFTER ENSURING THE *IMMEDIATE* AVAILABILITY OF OXYGEN. OTHER RESUSCITATIVE DRUGS, CARDIOPULMONARY EQUIPMENT, AND THE PERSONNEL NEEDED FOR PROPER MANAGEMENT OF TOXIC REACTIONS AND RELATED EMERGENCIES (See also ADVERSE REACTIONS and PRECAUTIONS). DELAY IN PROPER MANAGEMENT OF DOSE-RELATED TOXICITY, UNDERVENTILATION FROM ANY CAUSE AND/OR ALTERED SENSITIVITY MAY LEAD TO THE DEVELOPMENT OF ACIDOSIS, CARDIAC ARREST AND, POSSIBLY, DEATH.

...may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than in nonasthmatic people.

PRECAUTIONS

General: The safety and effectivness of lidocaine depend on proper dosage, correct technique, adequate precautions, and readiness for emergencies. Standard textbooks should be consulted for specific techniques and precautions for various regional anesthetic procedures.

Resuscitative equipment, oxygen, and other resuscitative drugs should be available for immediate use. (See WARNINGS and ADVERSE REACTIONS). The lowest dosage that results in effective anesthesia should be used to avoid high plasma levels and serious adverse effects. Syringe aspirations should also be performed before and during each supplemental injection when using indwelling catheter techniques. During the administration of epidural anesthesia, it is recommended that a test dose be administered initially and that the patient be monitored for central nervous system toxicity and cardiovascular toxicity, as well as for signs of unintended intrathecal administration before proceeding. When clinical conditions permit, consideration should be given to employing local anesthetic solutions that contain epinephrine for the test dose because circulatory changes compatible with epinephrine may also serve as a warning sign of unintended intravascular injection. An intravascular injection is still possible even if aspirations for blood are negative. Repeated doses of lidocaine may cause significant increases in blood levels with each repeated dose because of slow accumulation of the drug or its metabolites. Tolerance to elevated blood levels varies with the status of the patient. Debilitated, elderly patients, acutely ill patients and children should be given reduced doses commensurate with their age and physical condition. Lidocaine should also be used with caution in patients with severe shock or heart block.

Lumbar and caudal epidural anesthesia should be used with extreme caution in persons with the following conditions: existing neurological disease, spinal deformities, septicemia and severe hypertension.

Local anesthetic solutions containing a vasoconstrictor should be used cautiously and in carefully circumscribed quantities in areas of the body supplied by end arteries or having otherwise compromised blood supply. Patients with peripheral vascular disease and those with hypertensive vascular disease may exhibit exaggerated vasoconstrictor response. Ischemic injury or necrosis may result. Preparations containing a vasoconstrictor should be used with caution in patients during or following the administration of potent general anesthetic agents, since cardiac arrhythmias may occur under such conditions.

...l an... (adequacy of ventilation) vital signs and the patient's ...consciouness should be accomplished after each ...tic injection. It should be kept in mind at such ...tlessness, anxiety, tinnitus, dizziness, blurred vision, ..., depression or drowsiness may be early warning ...central nervous system toxicity.

...nide-type local anesthetics are metabolized by the ...ylocaine Injection should be used with caution in ...with hepatic disease. Patients with severe hepatic ...ecause of their inability to metabolize local anes... ...ormally, are at greater risk of developing toxic ...oncentrations. Xylocaine Injection should also be ... caution in patients with impaired cardiovascular ...since they may be less able to compensate for functional changes associated with the prolongation of A-V conduction produced by these drugs.

Many drugs used during the conduct of anesthesia are considered potential triggering agents for familial malignant hyperthermia. Since it is not known whether amide-type local anesthetics may trigger this reaction and since the need for supplemental general anesthesia cannot be predicted in advance, it is suggested that a standard protocol for the management of malignant hyperthermia should be available. Early unexplained signs of tachycardia, tachypnea, labile blood pressure and metabolic acidosis may precede temperature elevation. Successful outcome is dependent on early diagnosis, prompt discontinuance of the suspect triggering agent(s) and institution of treatment, including oxygen therapy, indicated supportive measures and dantrolene (consult dantrolene sodium intravenous package insert before using).

Proper tourniquet technique, as described in publications and standard textbooks, is essential in the performance of intravenous regional anesthesia. Solutions containing epinephrine or other vasoconstrictors should not be used for this technique.

Lidocaine should be used with caution in persons with known drug sensitivities. Patients allergic to para-aminobenzoic acid derivatives (procaine, tetracaine, benzocaine, etc.) have not shown cross sensitivity to lidocaine.

Use in the Head and Neck Area: Small doses of local anesthetics injected into the head and neck area, including retrobulbar, dental and stellate ganglion blocks, may produce adverse reactions similar to systemic toxicity seen with unintentional intravascular injections of larger doses. Confusion, convulsions, respiratory depression and/or respiratory arrest, and cardiovascular stimulation or depression have been reported. These reactions may be due to intra-arterial injection of the local anesthetic with retrograde flow to the cerebral circulation. Patients receiving these blocks should have their circulation and respiration monitored and be constantly observed. Resuscitative equipment and personnel for treating adverse reactions should be immediately available. Dosage recommendations should not be exceeded. (See DOSAGE and ADMINISTRATION).

Information for Patients: When appropriate, patients should be informed in advance that they may experience temporary loss of sensation and motor activity, usually in the lower half of the body, following proper administration of epidural anesthesia.

Clinically significant drug interactions: The administration of local anesthetic solutions containing epinephrine or norepinephrine to patients receiving monamine oxidase inhibitors or tricyclic antidepressants may produce severe, prolonged hypertension.

Phenothiazines and butyrophenones may reduce or reverse the pressor effect of epinephrine.

Concurrent use of these agents should generally be avoided. In situations when concurrent therapy is necessary, careful patient monitoring is essential.

Concurrent administration of vasopressor drugs (for the treatment of hypotension related to obstetric blocks) and ergot-type oxytocic drugs may cause severe, persistent hypertension or cerebrovascular accidents.

Drug Laboratory test interactions: The intramuscular injection of lidocaine may result in an increase in creatine phosphokinase levels. Thus, the use of this enzyme determination without isoenzyme separation, as a diagnostic test for the presence of acute myocardial infarction may be compromised by the intramuscular injection of lidocaine.

Carcinogenesis, mutagenesis, impairment of fertility: Studies of lidocaine in animals to evaluate the carcinogenic and mutagenic potential or the effect on fertility have not been conducted.

Pregnancy: Teratogenic Effects. Pregnancy Category B. Reproduction studies have been performed in rats at doses up to 6.6 times the human dose and have revealed no evidence of harm to the fetus caused by lidocaine. There are, however, no adequate and well-controlled studies in pregnant women. Animal reproduction studies are not always predictive of human response. General consideration should be given to this fact before administering lidocaine to women of childbearing potential, especially during early pregnancy when maximum organogenesis takes place.

Labor and delivery: Local anesthetics rapidly cross the placenta and when used for epidural, paracervical, pudendal or caudal block anesthesia, can cause varying degrees of maternal, fetal and neonatal toxicity (See CLINICAL PHARMACOLOGY—Pharmacokinetics). The potential for toxicity depends upon the procedure performed, the type and amount of drug used, and the technique of drug administration. Adverse reactions in the parturient, fetus and neonate involve alterations of the central nervous system peripheral vascular tone and cardiac function.

Maternal hypotension has resulted from regional anesthesia. Local anesthetics produce vasodilation by blocking sympathetic nerves. Elevating the patient's legs and positioning her on her left side will help prevent decreases in blood pressure. The fetal heart rate also should be monitored continuously, and electronic fetal monitoring is highly advisable.

Epidural, spinal, paracervical, or pudendal anesthesia may alter the forces of parturition through changes in uterine contractility or maternal expulsive efforts. In one study paracervical block anesthesia was associated with a decrease in the mean duration of first stage labor and facilitation of cervical dilation. However, spinal and epidural anesthesia have also been reported to prolong the second stage of labor by removing the parturient's reflex urge to bear down or by interfering with motor function. The use of obstetrical anesthesia may increase the need for forceps assistance.

The use of some local anesthetic drug products during labor and delivery may be followed by diminished muscle strength and tone for the first day or two of life. The long term significance of these observations is unknown. Fetal bradycardia may occur in 20 to 30 percent of patients receiving paracervical nerve block anesthesia with the amide-type local anesthetics and may be associated with fetal acidosis. Fetal heart rate should always be monitored during paracervical anesthesia. The physician should weigh the possible advantages against risks when considering paracervical block in prematurity, toxemia of pregnancy, and fetal distress. Careful adherence to recommended dosage is of the utmost importance in obstetrical paracervical block. Failure to achieve adequate analgesia with recommended doses should arouse suspicion of intravascular or fetal intracranial injection. Cases compatible with unintended fetal intracranial injection of local anesthetic solution have been reported following intended paracervical or pudendal block or both. Babies so affected present with unexplained neonatal depression at birth, which correlates with high local anesthetic serum levels, and often manifest seizures within six hours. Prompt

TABLE I COMPOSITION OF AVAILABLE SOLUTIONS

PRODUCT IDENTIFICATION		FORMULA						
		SINGLE DOSE VIALS AND AMPULES			MULTIPLE DOSE VIALS			
Xylocaine (lidocaine HCl) Injection (Percent)	Epinephrine (dilution)	Sodium Chloride (mg/mL)	Sodium Metabisulfite (mg/mL)	Citric Acid (mg/mL)	Sodium Chloride (mg/mL)	Sodium Metabisulfite (mg/mL)	Citric Acid (mg/mL)	Methyl-Paraben (mg/mL)
0.5	None	8.0	None	None	8.0	None	None	1.0
0.5	1:200,000	N.S.	N.S.	N.S.	8.0	0.5	0.2	1.0
1.0	None	7.0	None	None	7.0	None	None	1.0
1.0	1:200,000	7.0	0.5	0.2	N.S.	N.S.	N.S.	N.S.
1.0	1:100,000	N.S.	N.S.	N.S.	7.0	0.5	0.2	1.0
1.5	None	6.5	None	None	N.S.	N.S.	N.S.	N.S.
1.5	1:200,000	6.5	0.5	0.2	N.S.	N.S.	N.S.	N.S.
2.0	None	6.0	None	None	6.0	None	None	1.0
2.0	1:200,000	6.0	0.5	0.2	N.S.	N.S.	N.S.	N.S.
2.0	1:100,000	N.S.	N.S.	N.S.	6.0	0.5	0.2	1.0

N.S. Not Supplied.
NOTE. pH of all solutions adjusted to USP limits with sodium hydroxide and/or hydrochloric acid.

(2)

Exhibit #9
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of February, 1991.

Name: Marietta Cross

Address: 1820 Cypress Ct
Missoula 59801

Telephone Number: 728-3756

Representing whom?

Self

Appearing on which proposal?

SB 172

Do you: Support?____ Amend?____ Oppose?✓

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 2-6-91
BILL NO. SB 172

Senator Eck and members of the committee: My name is Marietta Cross. I am a registered nurse employed in Missoula. My background is maternal child nursing, obstetrics and newborn care.

I am opposed to Senate Bill 172. Private and public health care providers have spent the last 75 years in developing standards for the care of mothers and babies. These standards have resulted in drastically reduced maternal and infant mortality rates.

This bill is of concern because it lowers a standard of care. Not only that, it creates an impression in the public mind that the services of a lay midwife are comparable to those of a licensed physician or professional certified nurse midwife. This is unnecessarily confusing and an affront to the public trust. The bill is an attempt to create pseudo-nurse midwives. It is unconscionable in that respect.

A lay midwife is a lay midwife. Licensing should be required, but let it end there. To create a board, bureau, and the resulting entity proposed by Senate Bill 172 is a misdirected use of human energy and resources. If home birth is the desire of a small segment of the population, then let them enter into it with a clear idea of the implication and responsibility and not with the quasi blessing of the State.

Thank you for your attention.

Marietta Cross, R.N.

February 6, 1991

Exhibit # 9
2-6-91 SB 172

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10 LOST/FOUND
11 NOTICES
12 INSTRUCTION
13 FREE
14 SERVICES
20 RUMMAGE
AUCTIONS

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12 INSTRUCTION

DANCE CLASSES - ELENITA BROWN. Internationally trained. Missoula-Stevensville-Hamilton-Darby. Preschool-adults. Pre-Dance, Ballet & Character, Jazz, Modern, Spanish, Dancercize. 777-5956.

Be your own boss! Tired of working for someone else? Large earning potential. Call 363-2299 ext. 190.

Now is a good time to begin the MARTIAL ARTS. Deadly self-defense & great conditioning. 7pm weekdays at 208 Main, Stevensville. 642-3636

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Golden Retriever/Border Collie pups, black & white, intelligent, playful & healthy. Parents on premises. Ready now. 777-2187.

14 SERVICES

Wallpaper/Painting. Interior/Exterior. Free estimates. Senior Discounts. 961-4182.

JOHN'S BUILDING - MAINTENANCE. Inside/outside. A to Z. 642-3600.

In a Hurry? Don't Worry! What? No Time!. Call Partners In Grime 961-4218, 961-4366.

INCOME TAX PREPARATION: You may benefit from professional assistance, especially if you have sold property, incurred employee business expenses, moved, or had any change occur in your business situation. We prepare all states. Call early for your appointment. Diane Ellis, Enrolled to practice before the Internal Revenue Service.
363-4020
Office: 809 S. 1st S., Hamilton

ROTO-ROOTER: COMPLETE SEWER AND DRAIN CLEANING. RESIDENTIAL, COMMERCIAL. 7 DAYS A WEEK, 24 HOUR EMERGENCY SERVICE. 363-2787.

Mother of 2 would like to babysit ages 3 & up. Fenced in yard. 363-1091.

My husband cleans house better than I do. Offices, too. 363-5094 Call Larry.

Business Insurance

LADIES: If you're pregnant, you'll need personalized prenatal care at affordable prices. Classes, prenatal visits, birth services are available. Free consultation. Annette Lewis, Certified Senior Midwife, call 363-5179 or 208-756-4411.

Home Remodeling & Repair. All phases of work. 363-1559.

LASER PRINTING from your disks. Word Perfect (4.2 & 5.0) Xywrite & other word proc. compatible w/Postscript laser printers. Top Quality Paper. Further design in Pagemaker available at Ravalli Republic, ask for Vicki.

JEAN'S CLEANING. Special Introduction. 1st hr. free. Established, Dependable, References. 961-3517. Also, firewood, all types.

Want housecleaning job. $6.00 hr. Experienced. 961-3985.

JIM NELSON BUILDERS Kitchen - Bath Remodeling. Basements finished, Ceramic tile, Drywall, Low winter rates. 777-5320.

Get an Edge on the Job Market. Professional Resumes start at $7.00. For this and other secretarial needs, call 363-5042.

REMODELING, decks, additions, roofing, siding, windows, doors, frame to finish. Free estimates. Richard Bailly, 961-4729.

Chimney Specialist. Metal or masonry. Install or repair. LEGACY Stove & Insert Sales. Brick, block, rock work. Mel's Masonry. 777-5346.

PERRY WOOD FLOORS for all your wood floor needs. Free es-

VW's WANTED - dead or alive. Import Auto, Stevensville. 777-5888.

WANTED: Color TV's not working, solid state only, also VCR's. 363-5310, 961-3464.

WANTED TO BUY: Dry logs, any species 16" blocks to tree length logs delivered. Price negotiable. 273-2596.

WANTED: 6'x80" sliding glass patio door in frame with screen. 363-6638.

31 HELP WANTED

Electronics Test Technician, part time, flexible hours. Must have min. 5 yrs. experience with digital & analog circuits at the board level. Must be familiar with all standard test equipment. Should have experience with microprocessor technology. Please submit letter or resume starting qualifications. 115 West 3rd St., Stevensville, MT.

Looking for responsible person to care for 11 year old boy after school in your home. Call 363-6030 after 6pm.

Bartender needed nights & weekends. Experience preferred, but not necessary. Apply at Cedars.

Companion for elderly lady. Call 363-2911 after 6pm.

Stevensville secretary wanted for busy office. Computer, insurance & organizational skills helpful.

Quarterhorse stud. Line back dun, gentle disposition. Willing to trade. Call 777-2319 ask for Linda.

FARRIER Shoe and Trimming. Gary Heth. Phone 777-2153.

Older welch pony, $150. 2 yr. Arab filly, $400. 363-1634 after 4pm.

Very sturdy, extra wide single horse trailer, $550. Ph. 961-4031 early or late.

Philosophy & Expertise of Horse Schooling. Balanced riding, reining - our specialty. Also driving, etc. Full until Feb. 1st. See our schooled & started colts, also tapes. Call Robert "Bud" Schueler, 363-6849.

2nd & 3rd alfalfa. Black 2 yr. old Percheron Thoroughbred. Quarter colts. Longhorn bulls. 961-4606.

Butcher Lambs, $60 each. 642-3103.

Experienced carpenter in all phases of construction. New or remodeling. Senior discount. 961-3361.

LOWEST Priced Quality 3 Way in Town. Lower Prices on Quality IDAHO HAY Bale to Semi-Load. Delivery Available. Walt's Barn, 2020 N. 1st. 363-6621.

(2) 2-horse trailers, also horses for sale, broke & gentle, barrels, roping, etc. 961-4639.

Gentle bay gelding, 5 yrs old, $850. Phone 961-4031 early or late.

42 FARM PRODUCE

Exhibit # 9a
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of Feb, 1991.

Name: Mike Stephen

Address: Helena

Telephone Number:

Representing whom?

MT Nurses Assn.

Appearing on which proposal?

SB 172

Do you: Support?____ Amend?____ Oppose? X

Comments:

Support Sen Schmidt amendments

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Exhibit #96
2-6-91 SB 172

Amendments to SB 172
Requested by Sen. Paul Svrcek

1. page 4, line 17
Following: "period"
Insert: "where no risk factors have been identified"

2. page 8, line 6
Following: "hospital"
Insert: "and ~~may~~ is not a requirement for a hospital to provide."

3. page 15, line 19
Following: "hospital"
Insert: "physician referrals"

4. Page 16, line 20
Following: ~~and 6~~ phenylketonuria,
Insert: "(7) Rh screening of infant of Rh negative mother, for consideration of RhoGam ~~and referral for same.~~"

5. Page 3, Line 8
Following: "by"
Insert: "regulating and"

Exhibit # 96
2-6-91 SB 172

6. Page 4, line 8
Following: "period" on line 8
Insert: (8) "Postpartum" period means up to six weeks following birth."

7. Page 5, line 5
Following: "whose"
Insert: "present"

8. Page 8, line 2
Following: "birth;" on ~~line~~ line 2
Insert: "(i) intramuscular and subcutaneous injections;
(j) suturing necessary for episiotomy repair;
(K) communicable diseases affecting pregnancy, birth, newborn and postpartum periods;
(l) assessment skills;
(m) utilization of drugs authorized in Section 11."

10. ~~8.~~ Page 9, Line 3
Following: "conducted"
Insert: "in addition to the written examination"

9. ~~10.~~ Page 8, Line 24
Following: "qualifying"

Exhibit #9b
2-6-91 SB 172

11. Page 9, Line 18
Following: "the"
Delete: "study"
Insert: "educational"

12. page 9, line 14
Following: "midwife"
Insert: ", certified nurse-midwife or ~~[illegible]~~ physician licensed under Title 33, chapter 3,

13. Page 11, line 8
Following: "K"
Insert: "oral or intramuscular preparation

14. Page 11, line 9
Following: ~~line 8~~ "pitocin" on line 8
Insert: "(intramuscular)"
Following: "xylocaine"
Insert: "subcutaneous"

15. Page 15, line 20
Following: "phenylketonuria" on page 20
Insert:

15 Page 16, line 2,
Following: "B"
Insert: "and HIV [illegible]"

Exhibit #9b
2-6-91 SB 172

page 16, line 20

Following: ~~"phenylketonuria"~~ "phenylketonuria"
on line 20

Insert: "(7) screening for premature
later and/or other risk factors."

Exhibit # 10
2-6-91 SB 172

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 6 day of Feb, 1991.

Name: James F. Ahern

Address: 1720 9th Ave

Telephone Number: 442-1911

Representing whom?

Mt. Hospital Association

Appearing on which proposal?

Do you: Support?____ Amend?____ Oppose? ✓

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

24

MHA MONTANA HOSPITAL ASSOCIATION

1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

Testimony of James F Ahrens, President
Montana Hospital Association

SENATE HEALTH & WELFARE
EXHIBIT NO. 10
DATE 2-6-91
BILL NO. SB 172

Senate Bill 172

Before the
Senate Public Health, Welfare and Safety Committee

February 6, 1991

Madame Chairman and members of the committee, I am Jim Ahrens, President of the Montana Hospital Association. The Montana Hospital Association represents 58 member hospitals and affiliated societies. The association opposes the licensing of lay midwives. There is a severe obstetrical crisis in the state of Montana. The answer to this crisis lies not in the licensing of lay midwives, or alternate health providers, but in making medical resources available to women in those communities and counties who are without or soon will be without obstetrical services. The licensure of lay midwives further confuses this issue.

I would like to speak to you today about some specific issues that need to be addressed in the current legislation.

The bill's purpose states the practice of direct entry midwife affects the lives of the people of the state, and that Montanans need to have the bill in order to exercise their own right to give birth where and with whom they choose." Following that line of reasoning, it is our contention that Section 5, which establishes the composition of a board for the control of midwifery, should be radically changed. If the public has a compelling interest in this board, three members of the board should be members of the general public, one member should be a physician, and the fifth member should be a lay midwife. If there is such a compelling state interest, then the public should have the dominant membership on the board.

Also, there is no reason to request that all the board members "support the practice of direct entry midwifery". The governor should be free to choose whomever he wishes. Their support of the practice of midwifery should not be the basis for their appointment to the Board.

In Section 6, 3(h), the requirement of continuing education is very minimal. Instead of 10 hours annually for license and renewal, the association suggests there should be 30 hours of continuing education per year.

Section 7, paragraph 1, addresses about the qualifications of applicants for licensure. The criterion needs to be added that the person, in order to be eligible for licensure, should at least be a high school graduate.

Section 10 details the examination for a license to practice lay midwifery. It states that the license examination must be prepared by a certified nurse midwife designated by the board in consultation with the physician on the board. This is an abdication of responsibility. The board should be responsible for developing the examination, not one lay midwife. If the practice has reached the point of national prominence, then there should be a national standard or national examination available. The board may choose to do it in this fashion, but to have the legislature direct it to be done in this manner is unreasonable.

Also, the examination should consist of two parts, a written examination and a practical examination. Most personal professional licensure examinations consist of both written and practical examinations.

One assumes that the Department of Commerce will be involved in the operation of this newly developed board. If that is the case, the legislation is unclear as to the role of state government's relationship to the newly proposed lay midwifery board. What is it? What state agency will work with the board? There does not seem to be a clear intent in the legislation as to how state government will relate to the licensure of lay midwifery.

Section 21 should be amended to require that a licensed, direct entry midwife have her patients seen by a physician twice during the pregnancy. The language should be changed to read: "A licensed direct entry midwife is required to have all women accepted for midwifery care evaluated by a physician twice during the pregnancy".

The bill should be reworked and brought to the best technical state possible. Even after technical corrections, I would urge you to vote no on this piece of legislation.

SENATE HEALTH & WELFARE
EXHIBIT NO. 10
DATE 2-6-91
BILL NO SB 172

MHA MONTANA HOSPITAL ASSOCIATION
1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT 59604 • (406) 442-1911

Testimony of James F Ahrens, President
Montana Hospital Association

Senate Bill 172

Before the
Senate Public Health, Welfare and Safety Committee

February 6, 1991

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Also, there is no reason to request that all the board members "support the practice of direct entry midwifery". The governor should be free to choose whomever he wishes. Their support of the practice of midwifery should not be the basis for their appointment to the Board.

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The bill should be reworked and brought to the best technical state possible. Even after technical corrections, I would urge you to vote no on this piece of legislation.

SENATE HEALTH & WELFARE
EXHIBIT NO. 11
DATE 2-6-91
BILL NO. SB 172.

Will not testify.

February 6, 1991

Senator Eck and members of the Committee:

I wish to submit written testimony in opposition to Senate Bill 172.

I am Laurie Glover, a registered nurse from Great Falls. My background is in critical care and community health nursing. Presently I work with pregnant women and young children in a community health setting.

I believe the term "direct entry midwife" is very misleading to pregnant women. Use of this term misleads the public to believe the lay midwife has more qualifications than she does.

The provisions in SB 172 for education and training are, in my opinion, highly inadequate. Mothers and babies in Montana deserve the best medical care available. In our area, the income lay midwives receive from deliveries and associated services is significant enough for licensing requirements to include specialized education.

In summary, I urge you to consider the families and babies of Montana. Please ensure they have access to medical or certified nurse midwife prenatal care. If they choose to then obtain care from a lay midwife, please ensure they know what they are getting for their money.

Thank you.

Laurie Glover

SENATE HEALTH & WELFARE
EXHIBIT NO. 12
DATE 2-6-91
BILL NO. SB 172

February 6, 1991

Did not testify

Senator Eck and members of the Committee:

I wish to submit written testimony in opposition to Senate Bill 172.

I am Betty Hidalgo, a registered nurse from Great Falls. My professional background and experience is obstetrics and gynecology. I have been a Head Nurse and Clinical Specialist in obstetrics and have assisted in setting up educational programs for nurses in the Great Falls area. Currently, I'm employed as an OB-GYN nurse in a multi-specialty clinic and part time as a supervisor in a local hospital.

I oppose the term "direct entry midwife". This is misleading to the general public who do not necessarily know that their care will be given by a **LAY MIDWIFE.**

It has been stated that lay midwives will deliver low risk infants. I know how difficult it is at times to assess the position of the infant during labor. The unanticipated emergent situations that arise at the time of delivery can lead to infant distress and death if not treated immediately. Predicting an obstetrical emergency is not something that can be learned by observing a few deliveries and reading a few books.

I am not denying that problems sometimes arise during hospital deliveries. However, educated professionals and appropriate technology are available to respond urgently to emergent situations.

I have deep concern that no one is advocating for the unborn child. By not providing the best care for the unborn child is not one guilty of child abuse or certainly child neglect?

Licensing lay midwives will not assist in caring for pregnant women, nor is it the answer to access to care. My **grandmothers** received the kind of care proposed in SB 172; they would have preferred better care for themselves and their infants. By licensing lay midwives, we are taking a step backward. Please evaluate on a personal basis the type of care you would like to have for your children or grandchildren.

I charge you as our legislators to do the best for Montana's future generations. Let us not go backward in time, but together go forward to give Montanans good **healthy** beginnings.

Thank you for your careful consideration of this matter.

Betty Hidalgo

SENATE HEALTH & WELFARE
EXHIBIT NO. 12
DATE 2-6-91
BILL NO. SB 172

Senate Bill 172

Senator Eck and other committee members:

I am writing in opposition to licensure of lay midwives. I am currently the Head Nurse of Obstetrics at Marcus Daly Hospital in Hamilton.

I have worked in the area of obstetrics for 25 years during this time, I have delivered several babies in precipitous situations (before the MD arrived). There were no bad outcomes, and this is the outcome of most births. When there are no problems, there is very little a birth attendant does, other than assist the babies birth. However, 1 in 14 babies needs some form of resuscitation, sometimes only gentle stimulation to breathe, but when there are bigger problems, they are often immediate. If the births occured at home, there would be a chance mother or baby could die or be severely compromised before arrival at a hospital, or emergency center.

In the past few years, I have seen a dead baby from a home birth, a mother who bled profusely and had to hospitalized for blood transfusions, and recently an overdue baby, who spent several days in an intensive care nursery, directly related to it's overdue status. (These were all women who chose home births)

I have observed that some lay midwives generally are knowledgable and bring their clients to the hospital when they recognize problems. However, the clients are often antagonistic to the hospital situation, which increases their

(over)

As the mother of a handicapped daughter (seizure disorder) I would not wish for anyone, or their child, to go through similar experiences, especially when the problem could be prevented through safer perenatal care.

Mary Hackett, RN, BSN
Stevensville Montana

SENATE HEAL...
EXHIBIT NO. 13a
DATE 2-6-91
BILL NO SB 172

testify.

2-6-91

Senator Eck and members of the committee,

I am a mother of three, a nurse with thirteen years labor and delivery experience, a prenatal instructor and advocate for maternal child health.

I oppose SB 172 as written. I have seen many births, done "low risk", turn into nightmares within minutes (prolapsed cords, placental problems, hemorrhage, infant breathing problems).

I currently coordinate a rural prenatal care access program. It is my experience that many requests for home birth are based on financial concerns. With financial aid through State and federal programs, many women are relieved to deliver in a hospital, and have care by a physician.

Many misconceptions of "hospital birth", many hospital horror stories, have been allayed through ① birthing rooms ② our strong hospital based prenatal outreach, education, advocacy, and home visits. There are a multitude of services available to pregnant women throughout rural montana - WIC, low birthweight prevention projects, public health nurses, Nurses Service, etc.

Do not turn to a quick solution when so much is at stake ~ the quality of life of our infants.

Childbirth attendants cannot be certified by "watching so many births", and passing an exam.

Please consider strong educational requirements and training without shortcuts.

Certified-Nurse midwives are already practicing in Montana. These professionals should be used to supplement our OB providers shortage.

Ellen Brooks, LN, BSN
Hamilton, MT.

MINUTES

MONTANA SENATE
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Chairman Dorothy Eck, on February 13, 1991, at 3:05 p.m.
(Executive Action commenced at 3:05 p.m. The chairman called the public hearing to order at 4:10 p.m.)

ROLL CALL

Members Present:
Dorothy Eck, Chairman (D)
Eve Franklin, Vice Chairman (D)
James Burnett (R)
Thomas Hager (R)
Judy Jacobson (D)
Bob Pipinich (D)
David Rye (R)
Thomas Towe (D)

Members Excused: None

Staff Present: Tom Gomez (Legislative Council)
Christine Mangiantini (Committee Secretary)

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Announcements/Discussion:

EXECUTIVE ACTION ON SENATE BILL 172

Motion:

Senator Pipinich moved adoption of Amendments to SB 172. See Exhibit #1.

Discussion:

The chairman recognized Senator Pipinich who asked that Mona Jamison, representing the Midwifery Association, explain the amendments. The chairman recognized Mona Jamison who explained the proposed amendments.

Amendments, Discussion, and Votes:

The chairman recognized Senator Franklin who said her comments were met to avoid obstacles. She talked about the administration of pitosin. She said pitosin is given intravenously.

The chairman recognized Mona Jamison who said it will not be used to induce labor, but administered only after the birth of the child. She said Dr. Nelson concurred in this because of intense bleeding after birth, in some cases. She said they are not intending to use pitosin to induce labor.

The chairman recognized Senator Pipinich who moved to adopt the amendments.

There being no objection the motion to adopt Amendments #1 through 28 passed unanimously.

Motion:

The chairman recognized Senator Franklin who moved adoption of the amendment stated in Exhibit #2.

Amendments, Discussion, and Votes:

The chairman recognized Senator Franklin for an explanation of the proposed amendment.

Senator Franklin said she thought the assumption was that people do not want folks appointed to the board who may sabotage the board. She said the assumption is that the governor is making appointments and will make logical ones. To include the proposed language will ensure that the appointments will be appropriate.

The chairman recognized Mona Jamison who said that she would make the assumption that the governor would only make appointments that serve the public. However, she is familiar with the mechanics of the appointment process. She explained the process. She said by putting the language in you will develop a list in good faith. She said it is a matter of legislative intent.

Senator Franklin responded by saying that she had questions about the workability of it. She recommended cleaning up the language and being straightforward about it.

Chairman Eck said one of the amendments submitted by the Maternal Child Health Council called for a board which would also have a pediatrician, a certified nurse-midwife, which would add an additional two people. There was also a proposal for a five-member board with two nurse-midwives. She said the committee had a decision to make on the board membership.

The chairman recognized Senator Jacobson who said they would have another opportunity to discuss the board because she was introducing a bill that would provide an Allied Health Care Board for small groups such as this. The proposed legislation has a connecting clause to SB 172 and the naturopath's legislation.

Senator Towe called the question. The chairman called for the vote on adoption of the proposed amendment. There being 7 ayes and 1 nay by Senator Pipinich, the motion carried.

Motion:

The chairman recognized Senator Pipinich who moved to pass SB 172 as amended.

Amendments, Discussion, and Votes:

The chairman recognized Senator Franklin for a substitute motion to consider amendments from the Maternal Child Health Council.

Senator Towe called the question. The chairman called for a vote on the substitute motion. There being 7 ayes and 1 nay by Senator Pipinich, the substitute motion carried.

Senator Eck turned the chair over to Senator Franklin. The chairman recognized Senator Eck to explain the amendments (Exhibit #3). Senator Eck explained the amendments. The chairman recognized Mona Jamison who opposed increasing the number of semester hours of study.

Senator Eck asked Mona Jamison to respond to when a client is seeking emergency medical treatment and when the client's history is requested by the attending medical professional.

Ms. Jamison said she had no problem with the proposed amendment.

Senator Jacobson moved adoption of Amendment #4, (Exhibit #3).

There being no objection the amendment was adopted.

Senator Eck continued explaining amendments. The chairman recognized Senator Towe regarding Amendment #6. The chairman recognized Mona Jamison who said the original language included the word 'must' but because of the rules it was changed to 'may.' She said she would concur with the amendment.

Senator Jacobson moved adoption of Amendment #4 (Exhibit #3).

The roll was called. There being no objection the amendment was adopted.

Senator Eck continued by discussing Amendments #7 and #8 (Exhibit #3).

Senator Towe moved adoption of Amendment #9 (Exhibit #3). The roll was called. There being no objection the amendment was adopted.

Senator Eck discussed Amendment #10. Chairman Franklin commented about the definition of informed consent and called upon Mona Jamison.

Ms. Jamison responded by reading from the bill. She said the language was reasonable. She discussed Amendment #10 and said those who choose home birth are aware of the risks. She said a description of the risks of home birth that arise during home delivery would be negative.

The chairman recognized Senator Towe who said it is appropriate to explain to the person about to accept midwifery services what the risks are. He said he did not think it was unreasonable.

The chairman said it was presented in a punitive way. She continued by saying it was quite reasonable and in any clinical practice it is normal to inform the patients of the risks. She said the risks are implied but need to be more clearly defined.

The chairman recognized Senator Jacobson who asked about changing the amendment to read, "a description of the risks of home birth primarily those conditions that may arise during delivery."

The chairman recognized Senator Svrcek who said he thought the language discussed by Senator Jacobson was a good compromise. He made an alternative suggestion by saying he thought the board was required to come up with the form that involves informed consent. The form could include the problems that may arise with home birth. You would have a standard form and a standard list that the midwife would give to the client.

The chairman called upon Senator Towe who said much of the language will end up on a form anyway.

Senator Jacobson moved adoption of Amendment #10 to read as follows, "a description of the risks of home birth primarily those conditions that may arise during delivery." Renumber subsequent sections.

Senator Hager moved a substitute motion to have Amendment #10 read as stated in Exhibit #3.

The chairman called the roll on the substitute motion. The roll was answered as follows: Burnett (no), Franklin (yes), Hager (yes), Jacobson (no), Pipinich (no), Rye (yes), Towe (no), Eck (no). There being 5 nays and 3 ayes, the substitute motion failed.

The chairman called the roll on Senator Jacobson's motion to adopt the above-mentioned language for Amendment #10.

There being no objection the motion carried.

Senator Eck discussed Amendment #11 of Exhibit #3. Senator Pipinich moved adoption of Amendment #11.

The chairman recognized Mona Jamison about the language in Amendment #11. She said the word 'advised' was fine.

There being no objection the motion carried.

The chairman recognized Senator Towe who said someone during the hearing raised the question about the language on page 14, lines 16, 17. He said we should add language about advising the Department of Health about any adverse outcome. Senator Towe said on page 12 he would delete lines 20 through 22, regarding language about unbecoming conduct.

The chairman recognized Senator Rye who said the committee could pick apart the bill forever. He said he shared Senator Pipinich's impatience.

The chair was turned over to Senator Eck who recognized Senator Towe for a motion.

Senator Towe moved adoption of an amendment on page 12, line 20 following the word 'conduct' strike 'unbecoming a person licensed as a midwife or of conduct'. The language should read, 'is guilty of conduct detrimental to the interests of the public'.

The chairman called the roll. There being no objection the motion carried.

The chairman recognized Senator Franklin for a statement.

Senator Franklin said she will vote against the bill but she felt it was important to state her reasons. She said there are two arguments that move this bill forward. First, there are people who will never participate in conventional medical treatment and conventional birthing and it speaks to the needs of that constituency. Second, O.B. care is not available. She said she supports alternatives for care. She said she does not think conventional medical care has the last word on what is good for women, children or health care in all cases. She said she is concerned that this bill speaks in an inadequate way to lack of accessibility to O.B. care and what we are doing is saying it is O.K. for women to have third-world options as their only option. She would not like to see lay midwives affected in a punitive way for the practice of their care which is supportive and loving to women who want to participate. She is concerned that we are putting a band-aid on what is a serious problem for high quality care for women.

She supports safe home births and supports alternatives for women but feels this bill does not speak to the safety of those women.

The chairman recognized Senator Pipinich who moved adoption of Senate Bill 172 pass as amended.

Recommendation and Vote:

The roll was answered with all members voting aye except Senators' Franklin and Hager who voted nay.

EXECUTIVE ACTION ON SENATE BILL 134

Motion:

Senator Pipinich moved adoption of Amendments 1 through 10 on Exhibit #4.

Discussion:

The chairman recognized Tom Gomez who explained the amendments to the committee.

Amendments, Discussion, and Votes:

There being no objection the motion carried.

The chairman recognized Senator Rye who asked Mr. Gomez if the bill, as amended, will put Montana in line with the same regulations as the neighboring states.

Mr. Gomez said he looked at statutes of other states but could not discern that because their statutes did not speak to this level of specificity. There were references in the Washington and Idaho statutes to the federal food and drug labeling act.

Senator Rye said his understanding was that the purpose of the bill was to put Montana in line with neighboring states for same definitions and labeling. He said if this was not the case he would vote against the bill.

The chairman recognized Senator Towe who said in part the answer was that we are adopting the standards set forth in 9-CFR-319.19, if you look on page 8, line 7 of the bill. He said that was the principal one they were referring to.

The chairman recognized Senator Burnett who said this was in line with USDA recommendations and no matter what state you were in, the beef would have the same labels.

SENATE STANDING COMMITTEE REPORT

February 15, 1991

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 172 (first reading copy -- white), respectfully report that Senate Bill No. 172 be amended and as so amended do pass:

1. Page 2, line 11.
Following: "midwives"
Insert: "in order to achieve the goal of providing midwifery services to women during low-risk pregnancies"

2. Page 2, line 19.
Strike: "and"

3. Page 2, line 21.
Following: "forms"
Insert: "; and
(8) establishing criteria that limits an apprenticeship, as provided in [section 6]"

4. Page 3, line 8.
Following: "by"
Insert: "regulating and"

5. Page 4, line 5.
Following: line 4
Insert: "(7) "Postpartum period" means the period up to 6 weeks following birth."
Renumber: subsequent subsection

6. Page 4, line 17.
Following: "period"
Insert: "when no risk factors have been identified"

7. Page 4, lines 21 and 22.
Following: "members" on line 21
Strike: remainder of line 21 through "midwifery" on line 22

8. Page 5, line 5.
Following: "whose"
Insert: "present"

9. Page 6, line 14.
Following: "midwives"
Insert: "in order to achieve the goal of providing midwifery services to women during low-risk pregnancies"

10. Page 6, line 23.
Following: "least"
Strike: "10"
Insert: "14"

11. Page 7, line 3.
Strike: "and"

12. Page 7, line 5.
Following: "attendants"
Insert: "; and
(l) the establishment of criteria limiting an apprenticeship that, at a minimum, meets the standards established in [section 7]"

13. Page 7, line 10.
Following: line 9
Insert: "(i) must be a high school graduate;"
Renumber: subsequent subsections

14. Page 8, line 1.
Strike: "and"

15. Page 8, line 2.
Following: "birth;"
Insert: "(i) intramuscular and subcutaneous injections;
(j) suturing necessary for episiotomy repair;
(k) recognition of communicable diseases affecting the pregnancy, birth, newborn, and postpartum periods;
(l) assessment skills; and
(m) the use and administration of drugs authorized in [section 11];"

16. Page 8, line 6.
Following: "hospital"
Insert: ", nor may a hospital be required to provide such practical experience"

17. Page 8, line 24.
Following: "qualifying"
Insert: ", written"

18. Page 9, line 3.
Following: "conducted"
Insert: "in addition to the written examination"

19. Page 9, line 10.
Following: "the"
Strike: "study"
Insert: "educational"

20. Page 10, line 14.
Following: "midwife"
Insert: ", a certified nurse-midwife, or a physician licensed under Title 37, chapter 3,"

21. Page 11, line 5.
Following: line 4
Insert: "(4) A person who fails to achieve a passing grade on the examination may not engage in the practice of midwifery."

22. Page 11, line 8.
Following: "K,"
Insert: "oral or intramuscular preparations,"
Following: "pitosin"
Insert: "(intramuscular)"

23. Page 11, line 9.
Following: "xylocaine"
Insert: "(subcutaneous)"

24. Page 12, lines 12 and 13.
Strike: subsection (a) in its entirety
Insert: "(a) is using alcohol or other drugs to the point that job performance is impaired;"

25. Page 12, lines 20 and 21.
Following: "guilty" on line 20
Strike: remainder of line 20 through "or" on line 21

26. Page 14, line 16.
Strike: "and"
Insert: "(6) when the client is seeking emergency medical treatment and the client's history is requested by the attending medical professional; and"
Renumber: subsequent subsection

27. Page 14, line 22.
Strike: "may"
Insert: "must"

28. Page 15, line 7.
Following: "to"
Insert: "direct-entry"

29. Page 15, line 8.
Following: line 7
Insert: "(d) a description of the risks of home birth, primarily those conditions that may arise during delivery;"
Renumber: subsequent subsections

30. Page 15, line 8.
Strike: "encouraged"
Insert: "advised"

31. Page 15, line 19.
Following: "hospital"
Insert: "and physician referrals"

32. Page 16, line 12.
Following: "B"
Insert: "and, when appropriate, human immunodeficiency virus"

33. Page 16, line 19.
Strike: "and"

34. Page 16, line 20.
Following: "phenylketonuria"
Insert: ";
(7) Rh screening of the infant for RhoGAH treatment if the mother is Rh negative; and
(8) screening for premature labor and other risk factors"

35. Page 16, line 22.
Strike: "encouraged"
Insert: "advised"
Strike: "is encouraged to"
Insert: "shall"

36. Page 16, line 24.
Following: "physician"
Insert: "or certified nurse-midwife"

Signed: Dorothy Eck
Dorothy Eck, Chairman

2-15-91
Amd. Coord.

SB 2-15-91 3:30
Sec. of Senate

SENATE STANDING COMMITTEE REPORT

February 14, 1991

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 134 (first reading copy -- white), respectfully report that Senate Bill No. 134 be amended and as so amended do pass:

1. Title, line 6.
Strike: "RATHER THAN"
Insert: "AND"

2. Title, line 7.
Following: "OF"
Strike: "LEAN"
Insert: "FAT"

3. Title, line 8.
Following: "BEEF;"
Insert: "PROVIDING FOR A SUPER LEAN GRADE OF HAMBURGER AND GROUND BEEF"

4. Page 8, line 3.
Strike: "three"
Insert: "four"

5. Page 8, line 6.
Following: "have"
Insert: ":
(i)"
Strike: "lean"
Insert: "fat"
Strike: "less"
Insert: "greater"

6. Page 8, line 7.
Following: ";"
Insert: "and
(ii) a lean content of no less than 70%;"

7. Page 8, line 9.
Following: "have"
Insert: ":
(i)"
Strike: "lean"
Insert: "fat"
Strike: "less"
Insert: "greater"

8. Page 8, line 10.
Strike: "80%"
Insert: "22%; and
(ii) a lean content of no less than 78%;"

9. Page 8, line 12.
Following: "have"
Insert: ":
(i)"
Strike: "lean"
Insert: "fat"
Strike: "less"
Insert: "greater"
Strike: "85%"
Insert: "16%; and
(ii) a lean content of no less than 84%; and
(d) "super lean hamburger" or "super lean ground beef" may have:
(i) a fat content no greater than 12%; and
(ii) a lean content of no less than 88%"

10. Page 13, line 14.
Following: "~~maximum fat~~"
Insert: "maximum fat and"

Signed: Dorothy Eck
Dorothy Eck, Chairman

Urgent rite 2-14-91
Amd. Coord.

SB 2-14-91 8:55
Sec. of Senate

SENATE HEALTH, WELFARE
EXHIBIT NO. 1
DATE 2-13-91
BILL NO. SB 172

Amendments to Senate Bill No. 172
First Reading Copy

Requested by Senator Bob Pipinich
For the Senate Public Health, Welfare, and Safety Committee

Prepared by Tom Gomez
February 13, 1991

1. Page 2, line 11.
Following: "midwives"
Insert: "in order to achieve the goal of providing midwifery services to women during low-risk pregnancies"

2. Page 2, line 19.
Strike: "and"

3. Page 2, line 21.
Following: "forms"
Insert: "; and
(8) establishing criteria that limits an apprenticeship, as provided in [section 6]"

4. Page 3, line 8.
Following: "by"
Insert: "regulating and"

5. Page 4, line 5.
Following: line 4
Insert: "(7) "Postpartum period" means the period up to 6 weeks following birth."
Renumber: subsequent subsection

6. Page 4, line 17.
Following: "period"
Insert: "when no risk factors have been identified"

7. Page 5, line 5.
Following: "whose"
Insert: "present"

8. Page 6, line 14.
Following: "midwives"
Insert: "in order to achieve the goal of providing midwifery services to women during low-risk pregnancies"

9. Page 6, line 23.
Following: "least"
Strike: "10"
Insert: "14"

10. Page 7, line 3.
Strike: "and"

11. Page 7, line 5.
Following: "attendants"
Insert: ";
(l) the establishment of criteria limiting an apprenticeship that, at a minimum, meets the standards established in [section 7]"

12. Page 7, line 10.
Following: line 9
Insert: "(1) must be a high school graduate;"
Renumber: subsequent subsections

13. Page 8, line 1.
Strike: "and"

14. Page 8, line 2.
Following: "birth;"
Insert: "(i) intramuscular and subcutaneous injections;
(j) suturing necessary for episiotomy repair;
(k) recognition of communicable diseases affecting the pregnancy, birth, newborn, and postpartum periods;
(l) assessment skills; and
(m) the use and administration of drugs authorized in [section 11];"

15. Page 8, line 6.
Following: "hospital"
Insert: ", nor may a hospital be required to provide such practical experience"

16. Page 8, line 24.
Following: "qualifying"
Insert: ", written"

17. Page 9, line 3.
Following: "conducted"
Insert: "in addition to the written examination"

18. Page 9, line 10.
Following: "the"
Strike: "study"
Insert: "educational"

19. Page 10, line 14.
Following: "midwife"
Insert: ", a certified nurse-midwife, or a physician licensed under Title 37, chapter 3,"

20. Page 11, line 5.
Following: line 4
Insert: "(4) A person who fails to achieve a passing grade on the examination may not engage in the practice of midwifery."

21. Page 11, line 8.
Following: "K,"
Insert: "oral or intramuscular preparations,"
Following: "pitosin"
Insert: "(intramuscular)"

22. Page 11, line 9.
Following: "xylocaine"
Insert: "(subcutaneous)"

23. Page 12, lines 12 and 13.
Strike: subsection (a) in its entirety
Insert: "(a) is using alcohol or other drugs to the point that job performance is impaired;"

24. Page 15, line 19.
Following: "hospital"
Insert: "and physician referrals"

25. Page 16, line 12.
Following: "B"
Insert: "and, where appropriate, human immunodeficiency virus"

26. Page 16, line 19.
Strike: "and"

27. Page 16, line 20.
Following: "phenylketonuria"
Insert: ";
(7) Rh screening of the infant for RhoGAM treatment if the mother is Rh negative; and
(8) screening for premature labor and other risk factors"

28. Page 16, line 24.
Following: "physician"
Insert: "or certified nurse-midwife"

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2/13/91
BILL NO. SB 172

Amendments to Senate Bill No. 172
First Reading Copy

Requested by Senator Eve Franklin
For the Senate Public Health, Welfare, and Safety Committee

Prepared by Tom Gomez
February 13, 1991

1. Page 4, lines 21 and 22.
Following: "members" on line 21
Strike: remainder of line 21 through "midwifery" on line 22

SENATE HEALTH & WELFARE
EXHIBIT NO. 3
DATE 2/13
BILL NO. SB 172

Amendments to Senate Bill No. 172
First Reading Copy

Requested by Senator Dorothy Eck
For the Senate Public Health, Welfare, and Safety Committee

Prepared by Tom Gomez
February 13, 1991

1. Page 4, line 21.
Strike: "five"
Insert: "seven"

2. Page 5, lines 5 and 6.
Strike: subsection (b) in its entirety
Insert: "(b) one member who is an obstetrician;
(c) one member who is a pediatrician;
(d) one member who is a certified nurse-midwife; and"
Renumber: subsequent subsection

3. Page 7, lines 13 through 15.
Following: "childbirth" on line 13
Strike: remainder of line 13 through "following" on line 15
Insert: "at an institution accredited by this state, another state, or an independent educational accreditation organization for preparation to practice as a direct-entry midwife. The course of study must consist of at least 30 semester hours of study that includes but is not limited to courses and training in"

4. Page 14, line 16.
Strike: "and"
Insert: "(6) when the client is seeking emergency medical treatment and the client's history is requested by the attending medical professional; and"

5. Page 14, line 21.
Following: "woman"
Insert: "and from the father if he is participating in the decisionmaking regarding the unborn child acknowledging their acceptance of risk on behalf of the child"

6. Page 14, line 22.
Strike: "may"
Insert: "must"

7. Page 14, line 24.
Strike: "and"
Insert: ","

8. Page 14, line 25.
Following: "given"
Insert: ", and the father if he is participating in the decisionmaking regarding the unborn child"

9. Page 15, line 7.
Following: "to"
Insert: "direct-entry"

10. Page 15, line 8.
Following: line 7
Insert: "(d) a description of the risks of home birth, primarily those conditions that may arise during delivery and that may endanger the mother of the child without the immediate availability of hospital services;"
Renumber: subsequent subsections

11. Page 16, line 22.
Strike: **"encouraged"**
Insert: **"advised"**
Strike: "is encouraged to"
Insert: "shall"

Vote: Motion carried. EXHIBIT 4

EXECUTIVE ACTION ON SB 366

Motion: REP. STICKNEY MOVED SB 366 BE CONCURRED IN.

Motion/Vote: REP. STICKNEY moved to amend SB 366. EXHIBIT 5. Motion carried. EXHIBIT 6

Motion/Vote: REP. MESSMORE MOVED SB 366 BE CONCURRED IN AS AMENDED. Motion carried 17-3 with REPS. BOHARSKI, KASTEN and LEE voting no.

EXECUTIVE ACTION ON SB 393

Motion: REP. MESSMORE MOVED SB 393 BE CONCURRED IN.

Motion/Vote: REP. CROMLEY moved to amend SB 393. EXHIBIT 7. Motion carried unanimously.

Motion/Vote: REP. MESSMORE MOVED SB 393 BE CONCURRED IN AS AMENDED. Motion carried unanimously.

EXECUTIVE ACTION ON HB 93

Motion: REP. S. RICE MOVED HB 93 DO PASS.

Discussion:

REP. S. RICE submitted testimony on amendments. EXHIBIT 8

Motion/Vote: REP. S. RICE moved to amend HB 93. EXHIBIT 9. Motion carried unanimously.

Motion: REP. S. RICE moved to amend HB 93. EXHIBIT 10

Discussion:

REP. TUNBY asked the Department of Social and Rehabilition Services (SRS) if they agree with the amendments. Julia Robinson, Director, SRS, stated that these amendments are above the Governor's budget, however they are funded without pitting the General Fund. We have not taken a position on whether the Governor would report them. REP. S. RICE stated that there is no General Fund impact on the Health Care Association's amendment.

REP. KASTEN asked which bill are we adding these amendments to, the original bill or the gray bill. REP. S. RICE stated that these would be added to the gray bill.

Vote: Motion carried 19-1 with REP. MESSMORE voting no.

HEARING ON SB 172

Presentation and Opening Statement by Sponsor:

SEN. PAUL SVRCEK, Senate District 26, Thompson Falls, stated that in the last legislative session, by a large bipartisan margin, affirmed the legality of midwifery in the State of Montana. Because of legislative deadlines, they could not set up licensure of midwives because it would involve going through and summarizing the procedure. They met with as many concerned parties as they could on this issue. They spent a lot of time studying midwife legislation from other jurisdictions and they took information from the jurisdictions where they felt midwifery has worked. The Montana Medical Association supported this bill in front of the Audit Committee as supporting midwifery licensure. As a result of that, Mona Jamison, lobbyist for the midwives, has worked very closely with the person that at the time appeared before the Audit Committee was the spokesperson for the Montana Medical Association (MMA), Dr. Van Kirke Nelson. Since that time, there has been a split in the Montana Medical Association within the ranks. If they hold true to their position in the Senate Health and Human Services Committee, they will oppose this bill. We acknowledge the differences between the midwives and the MMA. We have continued to work with Dr. Nelson in the interest of making the best bill that we could.

Proponents' Testimony:

Dolly Browder, Direct Entry Midwife, Montana Midwifery Association, submitted written testimony for **P. J. Hennessy, M.D. EXHIBIT 11**

Teresa Snyder, Montana Midwifery Association, stated that she is the mother of two children. She has been a registered nurse in the State of Montana for the past 13 years and has been a registered nurse for about 20 years. She is currently a nursing professor with the Montana State University College of Nursing. Her second child was born with the assistance of an extremely skilled direct entry midwife. This option was the safest for her baby. The care her baby and her received was excellent. SB 172 provides a safe, well developed consistent standard of care for Montana women who choose this birthing option.

Pamela Rose, Direct Entry Midwife, Montana Midwifery Association, stated that she has been a midwife since 1982. She serves a portion of the state that is extremely rural and is agricultural in nature. We can't entice physicians to want to live and stay in these towns because of the economic depression. She brings prenatal care, child birth education, birth services, and post-partum care to these people. They would have to travel up to 120 miles for these services. She brings these services to them at their convenience for a fee.

Roberta Gerke, Harmony Family Services, stated that she has been a registered nurse for 35 years, most of that in obstetrical care in hospitals. She has spent four years as a lay midwife in

another state. During the time that she was a lay midwife after 25 years in hospital care, she learned more about common sense midwifery in her ten months association with the lay midwives than she learned in all of her hospital experience. These heritage people, who are the heritage of all obstetrics, taught the beginning obstetricians. By legalizing the midwives, you will be giving them the opportunity to practice as they should be practicing to answer the needs of Montana.

Larry Peterman, Montana Midwifery Association, stated that he works as a registered nurse in the emergency department in St. Patricks hospital in Missoula. He has a nine month old daughter who was born at home with the assistance of a midwife. In his work with Life Flight, an emergency helicopter, he has flown to every hospital within a 150 mile radius of Missoula and has worked with many doctors and nurses in Montana. The care provided by the midwife was excellent, conservative, and intelligent. The concern for the patient was genuine, the prenatal care was outstanding, and the midwife performed on a level compared very favorably with the level of care provided by the rest of the health system that he works with.

Pamela Shore, Montana Midwifery Association, stated that she is a nurse and is also a lawyer. She has two children that were born at home. Her first child was born in a rural setting and both births were attended by a direct entry midwife. Her midwife had wisdom and was not licensed, but was able to guide her through the birthing process with safety and dignity. She understands the need for the state to balance regulations with the rights of our people to have freedom of choices. She submitted testimony. **EXHIBIT 12**

Michelle Neal, Montana Midwifery Association, submitted written testimony for **Dr. Gregory Rice, M.D. EXHIBIT 13**

Mona Jameson, Montana Midwifery Association, stated that the issue is midwifery with regulations or midwifery without regulation. Continuing from the past through today and through the accepted date, if this bill passes, we continue to serve the people of this state without any regulation and without any standards. Even without standards we are providing a service, which some of the citizens like and to provide this in a healthy manner. With the bill and with the establishment of standards, education and clinical requirements, we should go even one step further in making these home births made as helpful as possible. Licensing and regulation is responsible. Should this bill fail, we will continue to serve the people diligently without standards and without examination.

Kim Ronshaugen, self, stated that there are always going to be people like herself who are going to have their children at home. They feel it is a safer alternative.

Connie Rubens, self, stated that they farm and ranch about 35

miles out of Great Falls. They experience a beautiful, safe home birth. Contrary to popular belief, lay midwives today, are trained in the field and are highly devoted to their job. The birth and the prenatal care was very well managed.

Debi Cokoran, self, stated that she has had four home births, three of them with a midwife. A midwife wasn't available for the fourth birth, and opposed to going to a hospital, her husband and her did it themselves. The other three were much nicer with a midwife present. With this legislation, it would make sure that midwives would be there for them.

Joe Ford, citizens, stated that his wife had a midwife deliver their baby. They were very pleased with the midwives ability.

VanKirke Nelson, submitted written testimony. **EXHIBIT 14**

Opponents' Testimony:

Barb Booher, Montana Nurses Association, submitted written testimony. **EXHIBIT 15**

Dr. Peter L. Burleigh, M.D., Montana Medical Association, submitted written testimony, **EXHIBIT 16**

Paulette Kohman, Montana Council for Maternal and Child Health, submitted written testimony. **EXHIBIT 17**

James Ahrens, President, Montana Hospital Association (MHA), stated that MHA looked at this issue a couple of years ago and opposed the legislation at that time. MHA has looked at it again on several occasions and still opposes it.

Jerome Loendorf, Montana Medical Association, (MMA), stated that MMA opposed this bill last session at which time it only authorized practice of midwifery for the reason that it contained no education or training requirements. MMA opposes it at this time because it is inadequate in those areas as we view it. He submitted written testimony. **EXHIBIT 18**

Betty Hidalgo, registered nurse, submitted written testimony. **EXHIBIT 19**

Questions From Committee Members:

REP. STICKNEY asked how many doctors practice in her area. **Ms. Shore** stated that her own experience is giving birth to a rural area where there were no doctors immediately available in the area.

REP. STICKNEY asked how many midwives do practice outside of Missoula and the Flathead Valley. **Ms. Shore** stated that there are two midwives practicing in the Great Falls area, two in the Billings area, one in Bozeman, two in Livingston, two in

Missoula, two in Kalispell and Whitefish.

REP. STICKNEY asked if there are midwives east of Billings. **Ms. Shore** stated that many midwives in those areas travel 100 to 200 miles to help people in those area where the midwife is. A lot of times the mothers will come to the areas. There are people who would like to become midwives in those areas, but will not because there is no licensing procedure for them to go through. They do not want to practice outside of the law.

REP. STICKNEY stated that women should have a choice, but really women can have a choice as long as they live in communities that already have many choices for them. Those who do not live in the areas where there are hospitals, doctors and midwives still aren't going to have a choice. **Ms. Shore** stated that no, some of them don't, but for the most part many midwives do give choices whether or not a physician is available.

REP. CROMLEY asked if there is minimum time period. **Ms. Jameson** stated that no there is no time period. Midwives do not pretend to be nurses, we are saying that the educational course of study must be approved by the board. If someone can complete that, but most significantly, pass the examination, then they would be licensed. The examination in this bill is directed that it will be written by a certified Montana Nurse Midwife that is a nurse in consultation with the physician on the board. A direct entry midwife will not be a part of the development of that exam.

REP. J. RICE asked how many states license midwives. **Ms. Jameson** stated that there are approximately 15 to 18 in good faith. There are a few states where all you have to do is file certification with that state and proceed to practice.

REP. J. RICE asked how many states have outlawed midwifery. **Ms. Jameson** stated that to the best of her knowledge there aren't any states that have outlawed midwifery.

REP. J. RICE asked if the midwives are not licensed, is there a capability of them paying liability insurance. **Ms. Jameson** stated that right now there is no opportunity to obtain liability insurance, because the insurance companies will not insure anybody that is not licensed. That means that every midwife in this state subjects their personal belongings and home to any kind of civil action for damages that may occur.

REP. J. RICE asked how much money do midwives charge for a birth. **Ms. Jameson** stated that they charge approximately $600 to $900. This amount covers all of the visits while the woman is pregnant, including the birth and the post partum period of up to six weeks. In these cases, the midwife goes to the home in most circumstances. It is not a 15 or 20 minute visit, but the amount of time spent with the midwife and the mother is a lot of time. It would probably compute to $1 an hour.

REP. J. RICE asked if the midwives would be interested in the future to include in the freedom of choice legislation that their services be covered by insurance. **Ms. Jameson** said no, that has never been discussed. The midwives are not legally into some of these benefits that are available. There is a provision that this bill will require direct entry midwives to advise all of their patients to consult with a physician or certified midwife at least two times during the pregnancy.

REP. MESSMORE asked what is the clinical hospital setting that is required for each midwife to acquire their experience. **Ms. Jameson** stated that the midwives do not believe that they can compel a hospital or doctor to offer their assistance. They have substantial concern about liability.

Closing by Sponsor:

SEN. SVRCEK stated that he can appreciate the horror stories that the opponents testified to. Certainly, none of us like to see death in anyway, nothing in that testimony can be directly linked to the practice of direct entry midwifery. Direct entry midwives are committed to low risk births. They already take every precaution to refer any time they feel there is an elevated risk to a physician. The nurses said that they oppose the practice of direct entry midwifery, that is not the issue. The issue is whether or not we are going to license the direct entry midwives. Most of the amendments that were added in the Senate Health and Human Services Committee are direct results of the input of the Montana Nurses Association. We have gone as far as we can, but we aren't going to adopt amendments that are punitive to the practice of midwives. This is not the bill the Montana Medical Association opposed two years ago. It is not our intention to turn direct entry midwives into nurses. The issue is not whether there will be direct entry midwifery in the State of Montana, the issue is licensing this practice to assure the direct entry midwifery meets a certain standard so that the public that makes use of those.

HEARING ON SB 284

Presentation and Opening Statement by Sponsor:

SEN. DOROTHY ECK, Senate District 40, Bozeman, stated that a few years ago they established a Children's Trust Fund. That fund has a board of directors and receives money from that donation on the income tax. This board ends up with an annual budget of about $50,000, and with that they have a charge of addressing the problem of child abuse and neglect in Montana. They address this through grants to private nonprofit groups around the state. Because those groups are very dedicated, it is amazing what they are able to do with a small amount of money. The board is only able to fund a relatively small number of the grant applications they receive and they can't give any of these groups the kind of money they really would need in order to do the job they want to

EXHIBIT 11
DATE 3-22-91
SB 172

p.j. hennessy, m.d.
243 NORTH AVE. EAST
MISSOULA, MT 59801
(406) 721-8849

Testimony for SB 172: Direct Entry Midwifery Licensing
House Human Services and Aging Committee
22 March 1991

I am a physician with a special interest in the health of women and children and I have a Master's in Public Health. During the fifteen years I have practiced in Montana, most of the time has been spent serving rural populations, many who lack health insurance.

As this Committee is well aware, the loss of obstetric providers and the closing of many rural hospitals have reached crisis proportions in some Montana counties. This situation has set the scene for a potential public health nightmare-- some Montana women may be forced to deliver babies without a birth attendant.

Midwifery in Montana has stepped in where physicians' malpractice liability has made them fear to tread. Midwives continue to help Montana women have safe births. This service is **especially** important when the women they serve lack access to traditional obstetric care.

Currently those who have been called to serve as midwives undertake a self imposed educational regimen. SB 172 will serve to strengthen and enhance the performance of those already attending births. It will also provide the means to an ongoing learning process through a rigorous standardized format.

This legislation is a critical component of the many bills that together will provide Health Care for Montanans. Immediate steps must be taken to insure access to care for pregnant women in our state. Our future citizens and their mothers deserve no less! It is imperative that you to support it!

EXHIBIT 12
DATE 3-22-91
SB 172

LIBBY CLINIC
211 EAST 2ND LIBBY, MONTANA 59923
TELEPHONE (406) 293-8711

March 6, 1991

Honorable Members
House of Representatives
State Capitol
Helena, Mt 59601

Gentlemen:

I would strongly urge you to support Senate Bill 172, which is for licensure of lay midwives in the State of Montana.

I am a family physician who has had an active obstetric practice in Libby for the last 14 years. I have worked with several midwives, both certified nurse midwives and lay midwives over the years and have seen how they have significantly improved the quality of obstetrical care here. I would like to see this continue in the future, and I think it is essential for midwives to be licensed for them to continue practicing in this modern era of medicine.

Licensure would better insure that the midwives practicing in the state have minimum standards and have some peer review process. As time goes by, licensure would lead to a more established conscientious group of midwives in the state who can insure and continue to insure good prenatal care for the babies of the future.

This has some significant practical ramifications as well. At the present time, you probably all are aware of the significant problems we're having with lack of access to prenatal care that is contributing to an increase in infant morbidity and mortality rates in the state. I think licensure here would be one small step that can help in the future with diminishing the number of patients who do not have access to good medical care.

In summary, I would strongly urge you to support the bill, Licensing Midwives, that's presented before you.

Sincerely,

Greg Rice

Gregory A. Rice, MD

EXHIBIT 14
DATE 3-22-91
SB 172

The American College of Obstetricians and Gynecologists
DISTRICT VIII

Office of the Vice Chairman
Montana Section
Van Kirke Nelson, M.D.
210 Sunnyview Lane
Kallispell, MT 59901
(406) 752-5260

March 21, 1991
Thursday

Representative Angela Russell
Chairperson
House Human Services and Aging
Capitol Building
Helena, Montana 59620

Re: Senate Bill #172

Dear Representative Russell:

Though I do not support lay or "direct entry midwifery" I must, knowing the intent of the 51st and 52nd Montana Legislature, testify on behalf of Montana Obstetricians and Gynecologists on the licensing of "direct entry midwifery" (lay midwifery). To oppose or take no position in this issue, clearly makes no contribution to the uncontrolled practice of lay midwifery in the State of Montana.

The American College of Obstetricians and Gynecologists supports the right of the pregnant woman to informed consent while recognizing that at the same time the woman assumes responsibility for decisions which she makes in the interest of her own health and the health and welfare of her infant. Government and its agencies have a responsibility to ensure that inadequate trained personnel and unsafe facilities are not approved.

Senator Paul Svrcek stated in his closing arguments on Senate Bill #172 before the Senate Public Health, Welfare and Safety Committee, that the practice of lay midwifery in Europe and third world countries has demonstrated a lower neonatal death rate per newborn than in the United States. That is true if you use the statistics from the U.S. To my knowledge there is no third world country that has a neonatal death rate as low as that enjoyed by the State of Montana - 4.8 deaths per 1,000 deliveries.

As to training and education, the present requirements of Senate Bill 172 are sadly lacking. Testimony was provided by advocates of "direct entry" or lay midwifery, that the World Health Organization supported the practice of midwifery. The World Health Organization also is concerned about the education

EXHIBIT 14
DATE 3-22-91
SB 172

Office of the Vice Chairman
Montana Section
Van Kirke Nelson, M.D.
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of midwives. Utilizing their own statement "midwives should have a minimum of three years of formal training and at least one year of nursing. For those midwives who have already completed nursing education, two years of midwifery education is the minimum requirement."

The American College of Nurse-Midwives has set comparable additional standards in the United States which are also supported by the American College of Obstetricians and Gynecologists. The certified nurse-midwife meets these standards. Lower standards are unacceptable for the care of women in the United States.

I enclose a copy of a quote from "Maternity Care in the World," a joint publication of IFGO and the International Confederation of Midwives, the organization representing the midwives in third world countries of whom Senator Svrcek alluded to in his testimony. Clearly, you can't compare that training with the minimum of training requested in present Senate Bill 172.

Several amendments to the present bill have already been made and included in the present bill, both by working directly with Mona Jamison, lobbyist for the midwives and through the senate hearing. Further amendments still need to be made to make licensure of "direct entry midwifery" protective of those Montana women and their unborn infants who seek to utilize home delivery as opposed to hospital attended delivery.

These proposed amendments are attached to this document.

Thank you very much for your consideration and thank you for your service to Montana during the 52nd Legislature.

Cordially,

Van Kirke Nelson, M.D.
Vice Chairman
Montana Section American College
of Obstetricians and
Gynecologists

VKN:db

EXHIBIT 14
DATE 3-22-91
SB 172

The American College of Obstetricians and Gynecologists
DISTRICT VIII

Office of the Vice Chairman
Montana Section
Van Kirke Nelson, M.D.
210 Sunnyview Lane
Kallispell, MT 59901
(406) 752-5260

PROPOSED AMENDMENT - SENATE BILL #172

1. Page 2, line 4
Following: "the"
Strike: "state"
Insert: "states"
Following: "New Hampshire"
Insert: "and New Mexico and the city of El Paso, Texas"

Comment: Both New Mexico and the City of El Paso have established excellent protocol for the practice of lay midwifery and should be included with those of New Hampshire for review by the board of direct entry midwifery.

Van Kirke Nelson, M.D.

EXHIBIT 14
DATE 3-22-91
SB 172

The
American
College of
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DISTRICT VIII

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Kallispell, MT 59901
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PROPOSED AMENDMENT - SENATE BILL #172

2. Page 4, line 9
Following: "a"
Insert: "lay"
Following: "person"
Insert: "provider"

Comment: Nomenclature is important to maintain on a state by state basis as all states use the nomenclature of "lay midwife." "Direct entry midwife" has been coined in New York state by lay midwives, though not a nationally accepted term. If Montana chooses to use "direct entry midwife" they should at least clarify in definitions.

Van Kirke Nelson, M.D.

EXHIBIT 14
DATE 3-22-91
SB 172

The American College of Obstetricians and Gynecologists

DISTRICT VIII

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PROPOSED AMENDMENT - SENATE BILL #172

3. Page 5, line 9
Following: "of"
Strike: "five"
Insert: "six"

4. Page 5, line 13
Following: "(a)"
Strike: "three"
Insert: "two"

5. Page 5
Following: line 19
Insert: "(c) one member who is a physician whose present practice includes pediatrics;
(b) one member who is a certified nurse midwife; and"
Reletter following subsection.

Comment: Since this is a new group of licensees, whose training requirements are considerably less than have been required of nurses and doctors who perform the same service, it should, at least initially, be closely monitored.

Van Kirke Nelson, M.D.

EXHIBIT 19
DATE 3-22-91
SB 172

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PROPOSED AMENDMENT - SENATE BILL #172

6. Page 17, line 2
Following: "hospital"
Insert: "with cesarean section capability"

Comment: A client of a direct entry midwife must know that the nearest hospital may not have cesarean section capability and must be informed of same, and should be fully informed of the additional risk.

EXHIBIT 14
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The American College of Obstetricians and Gynecologists

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PROPOSED AMENDMENT - SENATE BILL #172

7. Page 19
Following: line 6
Insert: "(3) the Department of Health and Environmental Sciences shall prepare and submit to the board and the Legislative Audit Committee a summary of the information obtained from the birth certificates on file with the department concerning births assisted by direct entry midwives, the summary shall include:

1. Location of birth, including the county, city, health care facility or other place of birth.
2. The number of births attended by each direct entry midwife.
3. Month of pregnancy prenatal care began.
4. Number of prenatal visits.
5. Birth weight.
6. If the mother was transferred prior to delivery.
7. If the infant was transferred.

The summary shall cover the period beginning with the effective date of this act through October, 31, 1992. The summary may include comments by the department and be submitted on or before December 31, 1992. The board or legislative auditor may present this summary with its findings and recommendations for amendments to this act to the legislature."

EXHIBIT 14
DATE 3-22-91
SB 172

3. **Training of Midwives**

(a) A student should have 12 years' general education before starting midwifery training.

(b) The age for entry should be at least 18 years.

(c) The minimum period of midwifery training should be three years, one year of which should be allocated to nursing training. If a candidate is already a general trained nurse, she may take midwifery training in two years.

(d) The hours of theoretical instruction should occupy a minimum of 1/3 (one-third) of the total training time.

(e) In addition to teaching in obstetrics and neonatal paediatrics, the syllabus should include some instruction in basic sciences, anatomy, physiology, social sciences, parenteraft, preparation for childbirth, community care, analgesia, epidemiology, certain aspects of gynaecology and family planning.

(f) During training a student midwife should undertake the care of not less than 50 women in the prenatal period, 50 women during the course of labour and 50 women in the early postnatal period.

(g) No specified number of domiciliary confinements should be required but experience in the care of mother and baby at home is advisable.

(h) Training should be provided without charge to the student.

4. **Postgraduate Education**

(a) Compulsory refresher courses are desirable for all midwives at least every five years. These should be of at least two weeks' duration and the content should be both theoretical and practical.

(b) Midwives should be encouraged to attend conferences, lectures and teaching sessions arranged locally and nationally together with obstetricians, paediatricians, other doctors and personnel in other health professions. Employing authorities should be encouraged to grant the requisite leave with pay.

(c) All countries should set up a Central Body responsible for the control of midwifery training and practice and the introduction of new drugs and procedures. It should also have the responsibility for issuing a list of drugs authorized for use by midwives on their own responsibility.

Maternity Care in the World

Joint publication of IFGO and the International Confederation of Midwives.

Local File Number

Birth Number

CHILD

CHILD'S NAME (First)	(Middle)	(Last)	DATE OF BIRTH (Month, Day, Year)	SEX
1.			2.	

FACILITY—NAME (If not institution, give street and number)	CITY, TOWN, OR LOCATION OF BIRTH	COUNTY OF BIRTH	TIME OF BIRTH
4.	5.	6.	7.

7a. PLACE OF BIRTH

☐ Hospital ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Residence ☐ Other (Specify)

CERTIFIER

I certify that this child was born alive at the place and time and on the date stated.	DATE SIGNED (Month, Day, Year)	ATTENDANT'S NAME AND TITLE (If other than certifier) (Type/Print)
8. Signature	9.	10.

CERTIFIER'S NAME AND TITLE (Type or Print)	MAILING ADDRESS (Street Number or Rural Route Number, City or Town, State, Zip Code)
11.	12.

LOCAL REGISTRAR'S SIGNATURE	DATE FILED BY REGISTRAR (Month, Day, Year)
13.	14.

MOTHER

MOTHER—MAIDEN NAME (First, Middle, Last)	BIRTHPLACE (State or Foreign Country)	DATE OF BIRTH (month, day, year)
15.	16.	17.

RESIDENCE—STATE	COUNTY	CITY OR TOWN AND ZIP CODE	STREET AND NUMBER	INSIDE CITY LIMITS (Yes or No)
18a.	18b.	18c.	18d.	18e.

FATHER

FATHER'S NAME (First, Middle, Last)	BIRTHPLACE (State or Foreign Country)	DATE OF BIRTH (month, day, year)
19.	20.	21.

I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief	MOTHER'S MAILING ADDRESS (If same as residence, enter Zip Code only)
22. Signature of Parent or Other Informant	23.

23a. Permission is given to provide the Social Security Administration with information from this certificate to obtain a Social Security card for this child.

☐ Yes ☐ No Signature of mother:

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

	ANCESTRY—(Mexican, Puerto Rican, Cuban, Hmong, English, Tribal affiliation, etc.) (Specify below)	RACE—American Indian, Black, White, etc. (Specify below)	26. EDUCATION (Specify only highest grade completed)	
			Elementary/Secondary (0-12)	College (1-4 or 5+)
MOTHER	24a.	25a.	26a.	
FATHER	24b.	25b.	26b.	

PREGNANCY HISTORY (Complete each section)		MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)	DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)		
LIVE BIRTHS (Do not include this child)	OTHER TERMINATIONS (Spontaneous & induced at any time after conception)	MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. (Specify)	PRENATAL VISITS—Total Number (If none, so state)	MOTHER'S BLOOD TESTED (Yes or No) (Date)	
27a. Now Living ☐ None Number___	27b. Now Dead ☐ None Number___	27d. ☐ None Number___	30.	31.	32.
DATE OF LAST LIVE BIRTH (Month, Year)	DATE OF LAST OTHER TERMINATION (Mo., Yr.)	PLURALITY—Single, Twin, Triplet, etc. (Specify)	IF NOT SINGLE BIRTH—Born First, Second, Third, etc. (Specify)		
27c.	27e.	35a.	35b.		

36. APGAR SCORE		MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ No ☐ Yes If yes, enter name of facility transferred from:
1 Minute	5 Minutes	
36a.	36b.	37.

WHAT PROPHYLACTIC USED IN EYES?	INFANT TRANSFERRED? ☐ No ☐ Yes If yes, enter name of facility transferred to:
38.	39.

FOR STATE USE

Death—one year

Multiple

Live Birth(s)

Fetal Death(s)

40a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Shade all that apply ■)

Anemia (Hct. < 30/Hgb. < 10)	01	☐
Cardiac disease	02	☐
Acute or chronic lung disease	03	☐
Diabetes	04	☐
Genital herpes	05	☐
Hydramnios/Oligohydramnios	06	☐
Hemoglobinopathy	07	☐
Hypertension, chronic	08	☐
Hypertension, pregnancy-associated	09	☐
Eclampsia	10	☐
Incompetent cervix	11	☐
Previous infant 4000 ® grams	12	☐
Previous preterm or small for gestational age infant	13	☐
Renal disease	14	☐
Rh sensitization	15	☐
Uterine bleeding	16	☐
None	00	☐
Other _____ (Specify)	17	☐

40b. OTHER RISK FACTORS FOR THIS PREGNANCY (Complete all items)

Tobacco use during pregnancy ... Yes ☐ No ☐

Average number cigarettes per day _____

Alcohol use during pregnancy ... Yes ☐ No ☐

Average number drinks per week _____

Weight gained during pregnancy _____ lbs.

42. COMPLICATIONS OF LABOR AND/OR DELIVERY (Shade all that apply ■)

Febrile (> 100°F. or 38°C.)	01	☐
Meconium, moderate/heavy	02	☐
Premature rupture of membrane (> 12 hours)	03	☐
Abruptio placenta	04	☐
Placenta previa	05	☐
Other excessive bleeding	06	☐
Seizures during labor	07	☐
Precipitous labor (< 3 hours)	08	☐
Prolonged labor (> 20 hours)	09	☐
Dysfunctional labor	10	☐
Breech/Malpresentation	11	☐
Cephalopelvic disproportion	12	☐
Cord prolapse	13	☐
Anesthetic complications	14	☐
Fetal distress	15	☐
None	00	☐
Other _____ (Specify)	16	☐

43. METHOD OF DELIVERY (Shade all that apply ■)

Vaginal	01	☐
Vaginal birth after previous C-section	02	☐
Primary C-section	03	☐
Repeat C-section	04	☐
Forceps	05	☐
Vacuum	06	☐

44. ABNORMAL CONDITIONS OF THE NEWBORN (Shade all that apply ■)

45. CONGENITAL ANOMALIES OF CHILD (Shade all that apply ■)

Anencephalus	01
Spina bifida/Meningocele	02
Hydrocephalus	03
Microcephalus	04
Other central nervous system anomalies (Specify) _____	05
Heart malformations	06
Other circulatory/respiratory anomalies (Specify) _____	07
Rectal atresia/stenosis	08
Tracheo-esophageal fistula/Esophageal atresia	09
Omphalocele/Gastroschisis	10
Other gastrointestinal anomalies (Specify) _____	11
Malformed genitalia	12
Renal agenesis	13
Other urogenital anomalies (Specify) _____	14
Cleft lip/palate	1
Polydactyly/Syndactyly/Adactyly	1
Club foot	1
Diaphragmatic hernia	1
Other musculoskeletal/integumental anomalies (Specify) _____	1
Down's syndrome	2

Montana Nurses' Association
P.O. Box 5718 • Helena, Montana 59604 • 442-6710

EXHIBIT 10
DATE 3-22-91
SB 172

MNA TESTIMONY SB 172 DIRECT-ENTRY MIDWIFERY

Montana Nurses Association is in opposition to the practice of direct-entry midwifery. We have actively participated in amending this bill to make the use of the services of a direct-entry midwife as safe as possible. However, we feel that there is no substitute for formal education and clinical supervision in the learning process. In the area of caring for mothers and their infants, we feel that the highest standards of education, preparation and safety must be observed because so many lives are affected when there are problems in the childbearing process.

We would urge a no pass on this piece of legislation and thank you for your consideration of this bill.

a:testbod.doc

EXHIBIT 17
DATE 3-22-91
SB 172

3. Training of Midwives

(a) A student should have 12 years' general education before starting midwifery training.

(b) The age for entry should be at least 18 years.

(c) The minimum period of midwifery training should be three years. One year of which should be allocated to nursing training. If a candidate is already a general trained nurse, she may take midwifery training in two years.

(d) The hours of theoretical instruction should occupy a minimum of 1/3 (one-third) of the total training time.

(e) In addition to teaching in obstetrics and neonatal pediatrics, the syllabus should include some instruction in basic science, anatomy, physiology, social sciences, parentcraft, preparation for childbirth, community care, analgesia, epidemiology, certain aspects of gynecology and family planning.

(f) During training a student midwife should undertake the care of not less than 50 women in the prenatal period, 50 women during the course of labor and 50 women in the early postnatal period.

(g) No specified number of domiciliary confinements should be required but experience in the care of mother and baby at home is advisable.

(h) Training should be provided without charge to the student.

4. Postgraduate Education

(a) Compulsory refresher courses are desirable for all midwives at lease every five years. These should be of at least two weeks' duration and the content should be both theoretical and practical.

(b) Midwives should be encouraged to attend conferences, lectures and teaching sessions arranged locally and nationally together with obstetricians, pediatricians, other doctors and personnel in other health professions. Employing authorities should be encouraged to grant the requisite leave with pay.

(c) All countries should set up a Central Body responsible for the control of midwifery training and practice and the introduction of new drugs and procedures. It should also have the responsibility for issuing a list of drugs authorized for use by midwives on their own responsibility.

Maternity Care in the World
Joint publication of IFCO and the International Confederation of Midwives.

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INTERNAL MEDICINE
S.P. AKRE, M.D. Rheumatology
F.J. ALLAIRE, M.D.
D.E. ANDERSON, M.D.
R.D. BLEVINS, M.D. Pulmonary Disease
G.A. BUFFINGTON, M.D. Nephrology
S.J. EFFERTZ, M.D. Rheumatology
J.D. EIDSON, M.D.
K.A. GUTER, M.D. Oncology
P.A. KREZOWSKI, M.D. Endocrinology
T.J. LENZ, M.D.
B.L. MAYNARD, M.D.
W.N. MILLER, M.D. Gastroenterology
T.W. ROSENBAUM, M.D. Nephrology
G.D. SPENCER, M.D. Gastroenterology
J.D. WATSON, M.D. Cardiology

OBSTETRICS AND GYNECOLOGY
C.J. BELL, D.O.
P.L. BURLEIGH, M.D.
F.J. HANDWERK, M.D.
R.J. McCLURE, M.D.
G.K. PHILLIPS, M.D.
S.M. WARD, R.N., C. Certified Nurse Practitioner

NEURO-SCIENCES
D.E. ENGSTROM, M.D. Psychiatry
W.H. LABUNETZ, M.D. Neurology-EEG
E.E. SHUBAT, Ph.D. Psychology
T.J. KRAJACICH, Ph.D. Psychology

OPHTHALMOLOGY
A.A. JORDAN, JR., M.D.

ORTHOPAEDIC SURGERY
P.A. SUAREZ, M.D.

PEDIATRICS
J.M. EICHNER, M.D.
N.C. GERRITY, M.D.
J.R. HALSETH, M.D.
J.P. HINZ, M.D.
C.C. MATELICH, M.D.
N.J. MAYNARD, M.D.
J.G. ROSENFELD, M.D.
D.P. RUGGERIE, D.O. Pediatric Cardiology

SURGERY
W.P. HORST, M.D. Urology
R.E. LAURITZEN, M.D. General and Vascular
J.E. MUNGAS, M.D. Vascular and General
M.B. ORCUTT, M.D. General and Vascular
J.A. SCHVANEVELDT, M.D. Ear, Nose & Throat
L.M. TAYLOR, M.D. General and Thoracic
W.C. VASHAW, M.D. General and Vascular

FAMILY PRACTICE CENTER
J.A. ROSS, M.D.
J.W. SPEER, M.D.
T.C. WEILL, M.D.
1220 Central Avenue
771-0090

IMMEDIATE CARE CENTER
D.R. ENGBRECHT, M.D.
T.J. SWEENEY, M.D.
1220 Central Avenue
771-0000

ADMINISTRATION
W.D. TAYLOR
M.D. MISSIMER
J.C. KINNA

GREAT FALLS CLINIC
1400 TWENTY-NINTH STREET SOUTH
P.O. BOX 5012
GREAT FALLS, MONTANA 59403-5012
PHONE (406) 454-2171
FAX (406) 454-0455

22 March 1991

House Committee on Human Services
and Aging
State Capitol
Helena, MT 59620

Dear Representative:

I would like to address specific areas of the lay midwife bill. I have several areas of major concern.

The first is that the practice of midwifery at any level certainly is the practice of medicine. It involves doing histories, physical exams, ordering and interpreting laboratory data, as well as performing deliveries, which includes the use of surgical procedures, such as episiotomies and their repair, and may involve the use of anesthetic medications which have potential side effects, which can include death. I am further concerned that the management of pregnancy and laboring patients often involve complications which are very subtle in their presentation and often occur late in the course of labor, and can be life- and health-threatening to both the mother and the baby. The amount of training and experience that is needed to care for pregnancy and attend deliveries is far in excess of what is provided in this bill for the lay midwives.

My first concern with the bill itself is that the Board is made up of mostly lay midwives with only one member from the medical community. I would like to see an obstetrician or family practitioner who does obstetrics, a pediatrician, and a nurse midwife on the Board, as well as lay members.

I am concerned that the educational requirements in Section VII are too vague. Subsection 2 states that the applicant shall satisfactorily complete educational requirements in pregnancy and natural childbirth, approved by the Board. Subsections A through H identify these requirements, and for the most part these are extremely subjective and vague. Subsection 3 says that there shall be acquisition of practical experience which can occur at home, in a clinic, or in a hospital. However, the practical experience is qualified in that it does not have to be in a training program or under supervision. This suggests that standing around and watching things that happen in a hospital is considered practical experience and that the applicant does not have to partake in any way in the decision-making process or in the actual delivery. This would seem to me to be an extremely poor way to train oneself.

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SB 172

Subsection B states that they should have observed fifteen births; such a small number of births would not even provide a chance to observe many of the normal variations in labor and delivery, let alone the unusual life-threatening complications.

Subsection VI states that they should be certified in adult and infant cardiopulmonary resuscitation. I would assume that this is the same basic life-support program that is given to factory workers and secretaries across the nation and has a pass rate of 100% so that anybody who signs up for the course gets the card. I would not consider this a very secure guarantee that the lay midwife was skilled or accomplished at either maternal or neonatal resuscitation if the need should arise.

Section VIII is most distressing to me. It basically says that if an applicant passes the test, they are exempt from any of the requirements outlined in Section VII, with the exception that they need to have a basic life-support card. Section X outlines the test and states that it is to be made up by the Board and a nurse midwife. Thus, we have a Board that can make up a test on its own discretion with minimal consultation from one other person, and at their own discretion they can exempt all other requirements of the law with the exception of having to have a basic life-support card. There certainly is nothing in this bill to assure the people of Montana that lay midwives would be properly trained or tested. Section XX states that a lay midwife would recommend to a patient that she obtain from some other health care worker certain screening tests which are routinely provided for in prenatal care. It is certainly not clear as to who would interpret these test results, or who would be responsible for following the patient. It also very clearly gives the patient prerogative of going ahead with this or not. Subsection 3 would indicate that the alphafetoprotein test and ultrasound test referrals would be done upon the patient's request, which suggests that the patients would have to have a very firm medical background to know when they should request such tests. Subsection 5 states that non-stress testing would be done if "any other reasons indicate the testing". This entire subsection would indicate the patient has the right to request proper prenatal care, but that the lay midwife has no obligation to provide proper care unless the patient requests it, nor does the lay midwife even really need to know what proper prenatal care is.

Section XXI states that physician consultation is encouraged, but does not require the consultation nor give any format as to how that would be accomplished. Section XXIV is designed to provide some limited release of liability to physicians who are put in a position of being forced to accept and care for patients in a hospital setting who have been under the care of a midwife and are transferred to the hospital because of some complication. I feel that this is an extremely adverse position for a physician to be in because the patient does not

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want traditional medical care and is further disappointed by the fact that her plans for home delivery have been aborted by some type of complication. Because of this, there is a likelihood that they will arrive at the hospital with a very serious condition and that the outcome of that pregnancy may be jeopardized. The combination of an angry patient and a bad outcome make lawsuits highly likely, and in spite of the limited liability allowed by this bill, I feel physicians would be hesitant to care for these patients. Because current laws and hospital policies require hospitals to accept emergency care and physicians are required to see those patients in order to be on the hospital staff, physicians would not have a choice as to whether or not to care for these difficult and high-risk patients.

Thus, I feel this bill enables poorly trained people to engage in the practice of medicine in an area that has potential for severe and sudden complications. The only management for these complications is to take the patient to a hospital and require physicians to deal with them in the most adverse of situations. Thus, this bill is likely to lead to increased risks and possibly deaths of mothers or babies, as well as delays in obtaining proper treatment.

Sincerely,

Peter L. Burleigh, M.D.
PLB/jp

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Montana Council for Maternal and Child Health

2030 Eleventh Avenue, Suite 10 • Helena, Montana 59601 • (406) 443-1674

SUSTAINING MEMBERS

Healthy Mothers, Healthy Babies
The Montana Coalition

March of Dimes,
Montana Big Sky Chapter

Montana Academy of
Family Physicians

Montana Chapter,
American
Academy of Pediatrics

Montana Perinatal
Association

Montana Section,
American College of
bstetrics and Gynecology

Montana Section
Nurses Association of the
American College of
Obstetrics
and Gynecology

nodair Children's Hospital

TESTIMONY FOR THE HOUSE HUMAN SERVICES AND AGING
COMMITTEE
Re: SB 172, LICENSURE OF MIDWIVES
MARCH 22, 1991

I speak to you today on the public policy issues which SB 172 raises, both generally and as they relate to the training issue.

It seems to me that the home birth movement represents two different groups, those who see home birth as simply a cheaper alternative to hospital care, and those who see hospital care as inherently destructive to strongly held personal values.

The Montana Council for Maternal and Child Health takes the position that the first viewpoint is invalid when applied to self-trained lay midwives, and could endanger the lives of mothers and babies in Montana. If you mean to license self-trained lay midwives to fill in the gaps where physicians and fully-trained midwives are unavailable or unaffordable, you will be telling Montana's poor and rural women that they are second-class citizens, served by third-world standards of care. That reasoning should be rejected at the outset.

The only acceptable response to inadequate access to care is to provide the same range of quality health care options to every citizen, statewide. We have no business disguising this bill, as it stands, as a substitute for adequate access to quality health care for Montana's pregnant women.

The second position, which has been mentioned only in passing in past hearings, is indeed worthy of your consideration. There can really be no doubt that an impersonal hospital birth process is not always a pleasant one. Most of us don't care what indignity we must suffer, if it is necessary to help our babies arrive in this world safe and sound. We will endure tubes and wires, drugs and even surgery, to ensure a healthy birth. To the extent that this high technology hospitalization actually helps our children, we are willing to sacrifice comfort and the romance of intimate personal surroundings.

But when the momentum of changing technology begins to impose unnatural conditions on life itself, perhaps we should look at home birth as a reflection of a new paradigm: a rejection of artificial life support systems, a return to the basic values of accepting life

and death on its own terms. A baby who dies at home may indeed have survived at a hospital, but with lifelong disability and at enormous cost. The issues are as old as life itself, but can arise in an instant. Who should decide what course to take? Legislators? Doctors? Or the parents themselves, who have weighed their own values, felt the kick of life in the womb and know what they will miss?

But even if home birth means no artificial interference, it does not mean that home birth attendants need not be thoroughly trained. Indeed, it means that the highest standards of care should be available in the home, not the lowest. Home birth parents, choosing this option not out of need but after a thorough weighing of their own values, should not have to settle for a birth attendant whose qualifications are no more than high school graduation and the reading of enough books during an apprenticeship to pass a single examination with a score of 70%.

The concern of the Montana Council for Maternal and Child Health is to ensure that home birth parents have the information to make a fully informed choice, free of economic pressure, and are provided with the safest, best-trained birth attendants possible. Other states and international organizations have established standards for training which include classroom instruction at accredited institutions. The World Health Organization standard requires a three-year program of combined classroom and clinical training. Other states have incorporated this standard in their regulation of lay or direct-entry midwives. Our state should do no less.

Training for direct-entry midwives which meets this standard is available at accredited institutions. One is the Seattle Midwifery School, which is not only state-accredited for direct-entry midwifery but is currently developing a program to add nurse-midwifery in conjunction with the Pacific Lutheran University's School of Nursing. With this training, licensed direct-entry midwives in Washington are not restricted to home births but are full participants in clinics, hospitals and birth centers. They are even eligible for Medicaid reimbursement. With training that meets international standards, direct-entry midwives can begin to have an impact on the access to care issues I mentioned earlier.

Without adequate training requirements, licensure of lay midwives in Montana will only give a false sense of security to home birth parents. The Montana Council for Maternal and Child Health opposes SB 172 unless it is amended to include accredited training requirements. Proposed amendments are submitted separately, patterned after the language of SB 66, licensing naturopathic physicians.

Thank you for your attention.

Paulette Kohman
Executive Director

EXHIBIT 10
DATE 3-22-91
SB 172

Professional Midwifery in Washington: Questions and Answers

Midwifery Fact Sheet

What is the legal status of midwifery in Washington State?

● Washington state law recognizes two separate entry paths for professional midwives: *Certified Nurse-Midwifery* and *Licensed Midwifery*.

Certified Nurse-Midwives (CNMs) are educated in the disciplines of Nursing and Midwifery. Their certification from the American College of Nurse-Midwives entitles them to practice in most states, including Washington, where they are licensed under the state's Advanced Registered Nurse Practitioner's Act, RCW 18.88.

Licensed Midwives (LMs) have completed three years at a state-accredited midwifery school and passed a state licensing examination. They are licensed under the state's Midwifery Act, RCW 18.50. This type of midwifery education is based on the well-established European model for direct-entry midwifery, which does not require prior nursing licensure but includes relevant nursing skills in the training program.

How are midwives educated?

● Certified Nurse-Midwives are educated at one of 24 programs in the United States, accredited by the American College of Nurse-Midwives. Programs vary in length, with some granting the basic certificate in nurse-midwifery (9-12 months) and others a master's degree in addition to the basic certificate (18-24 months). Licensed Midwives have completed a three-year midwifery education program accredited by Washington State. Standards for education in these programs are consistent with those established by the International Confederation of Midwives and the International Confederation of Gynecology and Obstetrics.

All student midwives complete rigorous theoretical instruction as well as extensive supervised clinical experiences in all aspects of midwifery care.

Where in Washington State is midwifery training available?

● There are currently two programs in Washington accredited by the state to provide midwifery training: the Seattle Midwifery School, an independent three-year program, and the John Bastyr College, where naturopathic students may complete additional courses and clinical work to meet state requirements for midwifery licensure.

Presently, there are no educational programs for nurse-midwifery in Washington. Information regarding nurse-midwifery educational programs can be obtained from the American College of Nurse-Midwives, 1522 K Street, NW, Washington, D.C. 20005, (202) 289-0171.

Midwives' Association of Washington State
2425 16th Avenue South #300
Seattle, Washington 98144 or (206) 548-5766

Published by the Midwives' Association of Washington State, the professional organization of Certified Nurse-Midwives and Licensed Midwives in Washington State. 7/90

What services do nidwives provide?

- Midwives provide care during the normal childbearing cycle. They consult with physicians and may refer clients to them if complications arise. Their scope of practice includes:
  - Prenatal care;
  - Education and counseling regarding pregnancy, birth, and infant care;
  - Continuous support during labor;
  - Delivery of the baby;
  - Care of the newborn;
  - Postpartum care of the mother;
  - Family planning services

How do midwives practice?

- Midwives may practice independently or in groups with other midwives, physicians and other health care providers. Should deviations from normal occur, a midwife obtains consultation from a qualified physician and makes appropriate referrals. In an emergency, a midwife is trained and equipped to carry out life-saving measures.

  Midwives may conduct deliveries in hospitals, birth centers or home settings. They are licensed to perform all of the procedures which may be necessary during the course of normal pregnancy, birth and the postpartum/newborn period, including the administration of selected medications.

How prevalent is midwifery practice in Washington?

- Since 1975, the proportion of midwife-attended births in Washingtion has increased more the 50-fold, from .07% of all births to 4.3% in 1988. Currently, this proportion is about 20% higher than in the United States as a whole.

  In 1988, Washington's 200 midwives attended over 3000 births in 34 of the state's 39 counties. Two-thirds occured in hospitals, while the remaining one-third were in homes and licensed birth centers.

Do medical insurance plans cover midwifery care?

- Most private insurance plans do reimburse for midwifery care, but coverage is not universal. Medicaid reimburses both Certified Nurse-Midwives and Licensed Midwives.

Can midwives obtain malpractice insurance?

- Malpractice insurance policies are presently available for both Certified Nurse-Midwives and Licensed Midwives.

What is the Midwives' Association of Washington State?

- The Midwives' Association of Washington State (MAWS), founded in 1983, is the professional organization representing the united efforts of the state's Certified Nurse-Midwives and Licensed Midwives. It has established standards for midwifery practice, adopted a procedure for peer review, provides continuing education opportunities and lobbies for various issues related to maternal and child health in the state.

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22 March 1991

House Committee on Human Services
and Aging
State Capitol
Helena, MT 59620

Dear Representative:

I wish to submit written testimony in opposition to the lay midwife bill, **Senate Bill 172.**

I am Betty Hidalgo, a registered nurse from Great Falls. My professional background and experience is obstetrics and gynecology. I have been a Head Nurse and Clinical Specialist in obstetrics and have assisted in setting up educational programs for nurses in the Great Falls area. Currently, I am employed as an OB-GYN nurse in a multi-specialty clinic and part-time as a supervisor in a local hospital.

I oppose the term "direct entry midwife". This is misleading to the general public who do not necessarily know that their care will be given by a **LAY MIDWIFE.**

It has been stated that lay midwives will deliver low-risk infants. I know how difficult it is at times to assess the position of the infant during labor. The unanticipated emergent situations that arise at the time of delivery can lead to infant distress and death if not treated immediately. Predicting an obstetrical emergency is not something that can be learned by observing a few deliveries and reading a few books.

I have a deep concern that no one is advocating for the unborn child. By not providing the best care for the unborn child, is not one guilty of child abuse or certainly child neglect? Let us as a state insure health care for all pregnant women, infants, and children by looking at issues and reforms to:

- Expand Medicaid coverage for all pregnant woman and children up to 185% of the federal poverty level;
- Assist businesses with providing comprehensive health insurance coverage through premium subsidies, tax credit incentives, or the establishment of small business insurance pools;
- Streamline the Medicaid eligibility process and create a single point of entry for all related maternal and child health programs and services;
- Make programs accessible by providing transportation and child care, expanding service hours, and establishing nontraditional service sites in the community; and

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- Encourage women to obtain early and continuous prenatal care through public awareness campaigns, home visiting, patient education, and resource mothers.

The long-term goal is for healthy families, and to make them responsible and functional Montana citizens.

Licensing lay midwives will not assist in caring for pregnant women, nor is it the answer to access to care. My grandmothers received the kind of care proposed in SB 172; they would have preferred better care for themselves and their infants. By licensing lay midwives, we are taking a step backward. Please evaluate on a personal basis the type of care you would like to have for your wife, children or grandchildren.

I charge you as our legislators to do the best for Montana's future generations. Let us not go backward in time, but together to forward to give Montanans good **healthy** beginnings.

Thank you for your careful consideration of this matter.

Sincerely,

Betty Hidalgo

Betty Hidalgo, R.N.
BH/jp

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on March 27, 1991, at 4:15 p.m.

ROLL CALL

Members Present:
Angela Russell, Chair (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Stella Jean Hansen (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Jessica Stickney (D)
Rolph Tunby (R)

Members Excused: Tim Whalen & Carolyn Squires

Members Absent: Bill Strizich

Staff Present: David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

EXECUTIVE ACTION ON HB 93

Motion/Vote: **REP. S. RICE MOVED HB 93 DO PASS AS AMENDED.** Motion carried 15-5 with **REPS. RUSSELL, DOWELL, HANSEN, MESSMORE, and SQUIRES** voting no.

The committee had previously adopted amendments to HB 93.

EXECUTIVE ACTION ON SB 172

Motion: **REP. DOWELL MOVED SB 172 BE CONCURRED IN.**

Motion: **REP. DOWELL** moved to amend SB 172. **EXHIBITS 1 & 2**

Discussion:

REP. BOHARSKI asked if there was a difference between a low risk pregnancy and a pregnancy that is not high risk. **REP. LEE** stated that there will always be some risk.

REP. BOHARSKI stated that the low risk language could be a real problem. In the intent section it talks about "low risk" pregnancies and this amendment refers to not "high risk" pregnancies. **Mona Jamison, Midwifery Association,** stated that the reason for this amendment was there was a mistake in the Senate. The Nurses Association asked that they direct their practice towards low risk pregnancies, and that is their goal. Throughout the bill low risk pregnancy appears many times. Their goal is to identify high risk situations and refer them to physicians.

REP. LEE asked if there was a list of things used to identify a high risk pregnancy. **Ms. Jamison** said yes, it would be implemented through the eligibility criteria in order for it to be adopted.

REP. LEE asked if it would be better to identify those things that make the pregnancy high risk rather than to identify a situation by the lack or absence if that risk. **Ms. Jamison** stated that we tried to do that, but it ended up that there are many different states that have licensing. We decided to say that it is up to the board to develop that in consultation with the physician on the board.

REP. LEE asked if it would be better to identify this as not high risk, then you have a list of things that actually identify high risk. **Ms. Jamison** stated that it will be identified in the rules and then tied into what are considered high risk.

REP. BOHARSKI asked if we can identify low risk pregnancies. **REP. MESSMORE** stated that the only way to do that would be with the absence of the high risk factors.

Vote: Motion carried 18-2 with **REPS. JOHNSON and KASTEN** voting no.

Discussion:

REP. LEE stated that it seems to be a moot point that if an M.D. is not within 50 miles of a caesarean capacity hospital, he probably would not have the ability to do an at home caesarean. It really doesn't make much sense one way or the other.

Motion: **REP. BOHARSKI** moved to amend SB 172. Motion failed 5-15 with **REPS. BOHARSKI, LEE, MESSMORE, STICKNEY and TUNBY** voting aye.

Discussion:

REP. BOHARSKI stated that this is one of the best bills that we have had presented.

Motion: **REP. LEE MOVED SB 172 BE CONCURRED IN AS AMENDED.**

Discussion:

REP. MESSMORE asked what the training criteria is in the regulations. **Ms. Jamison** stated that the reason this is in there is that Dr. Nelson urged us to put it in. He felt that they were the toughest regulations in the U.S. As a result of the negotiations, the Midwives said they are the toughest laws, but they agreed to put them in.

REP. MESSMORE asked what the intent of the lay midwives is. **Ms. Jamison** stated that midwives want to practice as responsibly as possible. The midwives have already established visits to the State of Washington Midwifery school and are already working with them in trying to set up a satellite program.

REP. MESSMORE asked if that is a one year training program with an extended campus. **Ms. Jamison** said she doesn't know.

REP. STICKNEY stated that she is gravely concerned that the committee will be licensing people who do not have the training to be doing what they are doing. I still cannot support this bill.

REP. HANSEN stated that they are going to practice whether we let them or not. The practical aspect of that is that we would much rather see them regulated rather than not regulated. As far as putting our stamp of approval on it, that isn't the way to look at licensing. We are controlling the practice by licensing the practice. When you don't have licensing, then you don't have any control.

REP. LEE stated that midwives have been real easy to work with. They have not been a group that has been resistive to changes. They have proved to be good to their word. As time goes on we will find them established as a real viable alternative. He encouraged the midwives to come back to the committee and report how things are going and how else we might be able to assist them in providing a safe reliable service to people in Montana.

REP. BOHARSKI stated that it is with reluctance that he urges this committee to support this bill. Unlike the other bills, we made the decision last session to approve the practice of midwifery. I went against my will and agreed with that. This is a step that we don't have a choice in making.

Vote: Motion carried 18-2 with **REPS. KASTEN and MESSMORE** voting no.

Motion: **REP. DOWELL** moved to amend SB 172. **EXHIBITS 1 & 2**

Discussion:

REP. BOHARSKI asked if there was a difference between a low risk pregnancy and a pregnancy that is not high risk. **REP. LEE** stated that there will always be some risk.

REP. BOHARSKI stated that the low risk language could be a real problem. In the intent section it talks about "low risk" pregnancies and this amendment refers to not "high risk" pregnancies. **Mona Jamison, Midwifery Association,** stated that the reason for this amendment was there was a mistake in the Senate. The Nurses Association asked that they direct their practice towards low risk pregnancies, and that is their goal. Throughout the bill low risk pregnancy appears many times. Their goal is to identify high risk situations and refer them to physicians.

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REP. LEE asked if it would be better to identify this as not high risk, then you have a list of things that actually identify high risk. **Ms. Jamison** stated that it will be identified in the rules and then tied into what are considered high risk.

REP. BOHARSKI asked if we can identify low risk pregnancies. **REP. MESSMORE** stated that the only way to do that would be with the absence of the high risk factors.

Vote: Motion carried 18-2 with **REPS. JOHNSON and KASTEN** voting no.

Discussion:

REP. LEE stated that it seems to be a moot point that if an M.D. is not within 50 miles of a caesarean capacity hospital, he probably would not have the ability to do an at home caesarean. It really doesn't make much sense one way or the other.

Motion: **REP. BOHARSKI** moved to amend SB 172. Motion failed 5-15 with **REPS. BOHARSKI, LEE, MESSMORE, STICKNEY and TUNBY** voting aye.

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL

NAME	PRESENT	ABSENT
REP. ANGELA RUSSELL, CHAIR	✓	
REP. TIM WHALEN, VICE-CHAIR		
REP. ARLENE BECKER	✓	
REP. WILLIAM BOHARSKI	✓	
REP. JAN BROWN	✓	
REP. BRENT CROMLEY	✓	
REP. TIM DOWELL	✓	
REP. PATRICK GALVIN	✓	
REP. STELLA JEAN HANSEN	✓	
REP. ROYAL JOHNSON	✓	
REP. BETTY LOU KASTEN	✓	
REP. THOMAS LEE	✓	
REP. CHARLOTTE MESSMORE	✓	
REP. JIM RICE	✓	
REP. SHEILA RICE	✓	
REP. WILBUR SPRING	✓	
REP. CAROLYN SQUIRES		
REP. JESSICA STICKNEY	✓	
REP. BILL STRIZICH		✓
REP. ROLPH TUNBY	✓	

CS05HUMSER.MAN

anne

11:00
3-28-91
JOB

HOUSE STANDING COMMITTEE REPORT

March 28, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that Senate Bill 172 (third reading copy -- blue) be concurred in as amended .

Signed: Angela Russell
Angela Russell, Chairman

Carried by: Rep. Lee

And, that such amendments read:
1. Page 5, line 5.
Strike: "NO RISK FACTORS HAVE BEEN IDENTIFIED"
Insert: "the pregnancy is not a high-risk pregnancy"

2. Page 12, line 14.
Following: "K"
Strike: ","
Insert: "("

3. Page 12, line 15.
Following: "PREPARATIONS"
Strike: ","
Insert: ")"

4. Page 14, line 24.
Following: "through 23]"
Insert: " and if the other state extends similar privileges to direct-entry midwives licensed under [sections 1 through 4 and 6 through 23]"

5. Page 16, line 25.
Strike: "and"

6. Page 17, line 2.
Strike: "."
Insert: "; and"

7. Page 17.
Following: line 2
Insert: "(g) that a health care provider's liability in rendering care or assistance in good faith to a patient of a direct-entry midwife in an emergency situation is limited to damages caused by gross negligence or by willful or wanton acts or omissions."

EXHIBIT 1
DATE 3-27-91
SB 172

Amendments to Senate Bill No. 172
Third Reading Copy

Requested by Sen. Svrcek
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 28, 1991

1. Page 5, line 5.
Strike: "NO RISK FACTORS HAVE BEEN IDENTIFIED"
Insert: "the pregnancy is not a high-risk pregnancy"

2. Page 12, line 14.
Following: "K"
Strike: ","
Insert: "("

3. Page 12, line 15.
Following: "PREPARATIONS"
Strike: ","
Insert: ")"

4. Page 14, line 24.
Following: "through 23]"
Insert: " and if the other state extends similar privileges to direct-entry midwives licensed under [sections 1 through 4 and 6 through 23]"

5. Page 16, line 25.
Strike: "and"

6. Page 17, line 2.
Strike: "."
Insert: "; and"

7. Page 17.
Following: line 2
Insert: "(g) that a health care provider's liability in rendering care or assistance in good faith to a patient of a direct-entry midwife in an emergency situation is limited to damages caused by gross negligence or by willful or wanton acts or omissions."

EXHIBIT 2
3-27-91
SB 172

Amendments to Senate Bill No. 172
Third Reading Copy

Requested by Sen. Svrcek
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 20, 1991

1. Page 5, line 5.
Strike: "NO RISK FACTORS HAVE BEEN IDENTIFIED"
Insert: "the pregnancy is not a high-risk pregnancy"

2. Page 12, line 14.
Following: "K"
Strike: ","
Insert: "("

3. Page 12, line 15.
Following: "PREPARATIONS"
Strike: ","
Insert: ")"

4. Page 17, line 2.
Strike: "."
Insert: "; and"

5. Page 17.
Following: line 2
Insert: "(g) that a health care provider's liability in rendering care or assistance in good faith to a patient of a direct-entry midwife in an emergency situation is limited to damages caused by gross negligence or by willful or wanton acts or omissions."